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

AUGUST 1, 2024
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

TELECONFERENCE LOCATION:
1255 MOOSE DRIVE, HOBACK, WY 83001

BOARD OF DIRECTORS

Isabel Becerra, Chair
Supervisor Vicente Sarmiento, Vice Chair
Maura Byron
Supervisor Doug Chaffee
Blair Contratto
Clayton Corwin
Norma García Guillén
Veronica Kelley, DSW, LCSW
José Mayorga, M.D.
Trieu Tran, M.D.
Supervisor Donald Wagner, Alternate

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt

CLERK OF THE BOARD
Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_hSjX1AG6S8Wza1hzaloiGA
and Join the Meeting.
Webinar ID: **851 0015 9753**
Passcode: **118764** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report

ADVISORY COMMITTEE UPDATES

2. Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update

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

CONSENT CALENDAR

3. Minutes
   a. Approve Minutes of the June 6, 2024 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the March 13, 2024 Regular Meeting to the CalOptima Health Board of Directors' Quality Assurance Committee

4. Approve the Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

5. Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

6. Approve Reappointments and Appointments to the Whole-Child Model Family Advisory Committee

7. Ratify Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

8. Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)

9. Approve Modifications to CalOptima Health Policy GA.8053: Workplace Violence

10. Authorize Amendments to the CalOptima Health Program of All-Inclusive Care for the Elderly Home Care Ancillary Fee-For-Service Contracts

11. Approve Modifications to Policy GA.3201: Document Management Program

12. Adopt Resolution No. 24-0801-01 Approving and Adopting Amended CalOptima Health Human Resources Policies

13. Adopt Resolution No. 24-0801-02 Approving and Adopting Volunteers Aged 18 and Older as Employees for the Sole Purpose of Receiving Workers' Compensation Benefits

14. Approve Reappointments and Appointments to the Member Advisory and Provider Advisory Committees and Extend the Term for Two Seats on the Member Advisory Committee

15. Receive and File:
    a. May and June 2024 Financial Summaries
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

16. Approve Actions Related to a Contract with Advance OC to Conduct the 2024 Member and Population Health Needs Assessment

17. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

18. Approve Actions Related to Convening a Steering Committee and Conducting Community Listening Sessions to Explore Joining Covered California

19. Approve Actions Related to the Community Enrollers for Medi-Cal Notice of Funding Opportunity

20. Approve Actions Related to the Incentive Payment Program for Justice-Involved Services Learning Collaborative

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on August 1, 2024 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_hSjX1AG6S8Wza1hzaloiGA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
https://us06web.zoom.us/s/85100159753?pwd=uCbtrhkyCmF6v0k4i3A1TQWC2jnnDw.1

Or One tap mobile:
+16694449171,,85100159753#,,,,*118764# US
+13462487799,,85100159753#,,,,*118764# US (Houston)

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

Webinar ID: 851 0015 9753
Passcode: 118764

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

MEMORANDUM

DATE: July 26, 2024

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — August 1, 2024, Board of Directors Meeting

COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. CalOptima Health Board of Directors Welcomes Two New Members

Current terms for nearly all members of the Board, except the two Supervisorial seats and the standing seat for the Orange County Health Care Agency (HCA) director, will expire on August 3, 2024. Following a recruitment process over several months, the Orange County Board of Supervisors voted on June 25 to appoint two new individuals and reappoint all the Board incumbents who reapplied. All will serve four-year terms, effective August 4, 2024, through August 3, 2028. The new Board members are:

- Current or former hospital administrator: Brian Helleland, MHSA, Chief Executive, Providence St. Joseph Hospital
- Practicing licensed medical provider (not affiliated with a contracted health network): Cathy Green, RN, an actively licensed registered nurse

Returning Board members are:

- Practicing licensed physician (representative of a contracted health network): José Mayorga, M.D.
- Legal resident of Orange County: Blair Contratto
- Accounting or public finance professional or an actively licensed attorney: Norma García Guillén, J.D.
- Community clinic representative: Isabel Becerra
- Current CalOptima Health member or family member: Maura Byron

The two new Board members will participate in their first meeting on September 5. On behalf of the entire staff, I want to express my gratitude for the service of our continuing Board members as well as our two outgoing Board members, Clayton Corwin and Trieu Tran, M.D., who chose not to reapply.

B. New Street Medicine Programs Launching Soon

CalOptima Health's Street Medicine Program will soon be available in two new cities — Costa Mesa and Anaheim. On August 12, contracted provider Celebrating Life Community Health Center will begin offering medical and social services for people experiencing homelessness in Costa Mesa. We will be holding a press conference on August 21 in Costa Mesa to announce the program. Anaheim's Street Medicine Program is slated to begin on September 3, with services by Healthcare in Action. To prepare for this expansion, CalOptima Health has been leading Street Medicine Steering Committee meetings with fire personnel, local police departments, the county sheriff department, HCA and other organizations to discuss program operations and services. The Steering Committee is a partnership-

driven, collaborative effort to support the most effective and sustainable outcomes for our members experiencing homelessness. Furthermore, CalOptima Health engages our contracted providers to deliver our Street Medicine model of care that is specific to Orange County and does not include distribution of clean needles and drug paraphernalia. Recent media coverage of Healthcare in Action services in Los Angeles County did not make clear that our program is different.

C. CalOptima Health to Host Second Annual Back to School Health and Wellness Fair

CalOptima Health and the Orange County Department of Education are hosting a Back-to-School Health and Wellness Fair on Saturday, August 3, from 9 a.m.–1 p.m. at Columbus Tustin Park (14712 Prospect Ave., Tustin). Families can:

- Apply for CalFresh and Medi-Cal
- Receive free naloxone
- Receive shoes, food, bike helmets and backpacks (while supplies last)
- Receive free vision exams, eyeglasses, dental services, sports physicals and haircuts (by appointment)
- Access resources for basic needs
- Enjoy fun activities, including live music, magic and face painting

D. Final FY 2024–25 State Budget Agreement Announced

On June 22, Gov. Gavin Newsom and leaders of the California State Legislature announced a final agreement on the Fiscal Year (FY) 2024–25 state budget, which went into effect on July 1. Government Affairs staff prepared an analysis (see Page 7) discussing potential CalOptima Health impacts of the enacted state budget. Most notably, the final budget agreement restores several planned Managed Care Organization (MCO) tax investments for Medi-Cal provider rate increases that had been proposed to be eliminated in the governor's May Revision. However, total investments are still reduced when compared with the original agreement reached last year with the statewide MCO Tax Coalition of health care providers. Rate increases for some provider types will remain effective on January 1, 2025, some will be delayed until January 1, 2026, and others have been eliminated. Additional provider types not originally included in the MCO Tax Coalition will now also receive a portion of the investments. Finally, most of these investments will become inoperable if voters approve the related MCO Tax Initiative (Proposition 35) on the November 5, 2024, ballot (See Item E below). This final MCO tax agreement follows recent advocacy efforts by CalOptima Health and Orange County's safety net health care providers — including the Coalition of Orange County Community Health Centers, the Hospital Association of Southern California and the Orange County Medical Association — who distributed a joint letter to Orange County's state legislative delegation expressing our concerns with the May Revision proposal to divert MCO tax revenues to address the budget deficit.

E. Proposition 35 Qualifies for November 2024 Election

On July 3, California Secretary of State Shirley N. Weber, Ph.D., certified that the MCO Tax Initiative had submitted enough valid signatures and officially assigned it to the November 5, 2024, ballot as Proposition 35. If passed by voters, Proposition 35 would permanently extend the MCO tax — currently set to expire on December 31, 2026 — with strict funding allocations for Medi-Cal rate increases to a range of provider types to support quality and access to care. While CalOptima Health contributed to the coalition that helped prepare, negotiate and launch the initiative, at this point we are significantly restricted as a public agency from participating in what is now considered a political campaign.

F. U.S. Sen. Laphonza Butler Sponsors Federal Earmark Request

U.S. Sen. Laphonza Butler (D-CA) is sponsoring CalOptima Health's federal earmark request of $5 million for our proposed Safety Net Behavioral Health Workforce Development Program. Notably, this

was the senator's largest sponsored earmark in Orange County. This proposed program would supplement our current Provider Workforce Development Initiative to offer funding specifically to behavioral health providers. Our Government Affairs staff and contracted federal lobbyists are now working with Sen. Butler's office and the Senate Appropriations Committee to ensure the earmark is maintained throughout the development and finalization of FY 2025 federal appropriations legislation.

G. Supreme Court Decision Upholds Camping Ban on Public Property

On June 28, the U.S. Supreme Court ruled in the case of City of Grants Pass v. Johnson that the enforcement of generally applicable laws regulating camping on public property does not constitute "cruel and unusual punishment" as prohibited by the Eighth Amendment to the U.S. Constitution. Therefore, governments are permitted to enact "camping ban" laws that restrict unhoused individuals from sleeping on public property. CalOptima Health will continue to provide all our services — including Street Medicine, Community Supports, and other housing and homelessness initiatives — to improve the health of our unhoused members and help them reach the goal of stable housing. CalOptima Health is committed to working with all our partners — including providers, cities, community-based organizations and others — to ensure the ongoing success of these programs and to expand access to the quality care that all our members deserve.

H. Student Behavioral Health Incentive Program (SBHIP) Shares Progress Report

In May 2023, the CalOptima Health Board of Directors approved our $25 million SBHIP funding plan and the associated programs to be implemented by our partner organizations. Those organizations are Orange County Department of Education (OCDE) and all 29 Orange County public school districts, Hazel Health, CHOC, Western Youth Services, and HCA. Over the past 14 months, work has progressed rapidly, and CalOptima Health has met Department of Health Care Services (DHCS) milestones for reporting progress thus far. Below are a few accomplishments, and a more comprehensive summary is available on Page 11 of this report.

- Expanded behavioral health staff in 22 of the 29 school districts, resulting in an overall 17% increase in staffing across those districts combined.
- Opened the first of 10 SBHIP-funded WellSpaces at Marco Forster Middle School.
- Launched Hazel's Heart Program (telehealth counseling services for students at school or home) in 20 of the 29 Orange County public school districts, resulting in 296,850 students at 357 school campuses having access to telehealth services. In the first six months of operation, nearly 900 care inquiries were logged.
- Designed on-demand school-based mental health training modules.

I. Second Round of Grants Opens for Provider Workforce Development Initiative

CalOptima Health has announced up to $5 million in competitive grants for programs and partnerships that train, retain and develop health professionals (non-physician primary care, behavioral health and allied health) in Orange County to serve Medi-Cal members. This funding will prioritize, but is not limited to, programs focused on increasing the behavioral health workforce serving CalOptima Health members. Orange County health systems, health care provider organizations and community organizations are eligible to apply for a maximum grant of up to $1 million per organization. This second round of grants is part of CalOptima Health's five-year, $50 million Provider Workforce Development Initiative. The grant application closes on Monday, August 19, 2024, at 5 p.m. A Notice of Funding Opportunity is posted on our website.

J. CalOptima Health Launches Key Advertising Campaigns

- Program of All-Inclusive Care for the Elderly (PACE) Campaign
  In late May, we launched a new campaign to help distinguish CalOptima Health PACE as the premier PACE program in Orange County. Capturing authenticity by picturing our actual PACE participants, the campaign conveys our commitment to the highest standards of individualized care, social connection, activities and support. The campaign tagline is "Senior Care to Keep You Active and Living at Home" and emphasizes that CalOptima Health offers complete medical care that goes above and beyond. Running in English, Spanish and Vietnamese, the multimedia campaign includes print, outdoor, digital display, social media, TV and search engine advertising.
- Medi-Cal Expansion Campaign
  In April, we launched a strategic campaign to target Latino residents ages 26–54 to increase awareness of the expanded Medi-Cal program and encourage enrollment among newly eligible individuals. Scheduled to run until June 2025, the campaign leverages messaging developed by DHCS and conveys CalOptima Health's commitment to ensuring all eligible individuals have access to health coverage. The multifaceted campaign encompasses various traditional and digital advertising channels to effectively reach and engage the targeted audience.

K. Naloxone Distributed to Providers and Community-Based Organizations (CBOs)

On June 21, CalOptima Health hosted a Naloxone Distribution Event (part of our Drive to Revive Campaign) at our building to distribute free doses of naloxone to medical providers and CBOs. We distributed 16,608 doses of naloxone at the event and are also offering ongoing delivery of naloxone to our providers and others. Providers interested in obtaining naloxone can email naloxone@caloptima.org for information about placing an order.

L. CalOptima Health Gains Media Coverage

Reflecting the media's recognition of our ongoing innovation and program development, CalOptima Health continues to receive robust coverage:

- As a result of our June 5 press conference to announce CalOptima Health's $5 million grant to UCI's nursing program, we received the following coverage:
  - On June 5, ABC and NBC ran packages covering the news, and KNX Radio ran two segments with audio from our event, which as streamed live on social media channels.
  - On June 6, the Orange County Register featured an article on the front of the Local Section.
- Following the June 17 distribution of our Provider Rate Increase press release and posting on PR Newswire, we received media coverage by OC Register, KNX Radio and KFI Radio. Industry trade publications also ran the news, including Becker's Payer Issues, Modern Healthcare, Healthcare Finance News and KFF Health News.
- On June 23, the front page of the Orange County Register featured the results of a first-ever report about housing conditions for the transgender, gender-diverse and intersex (TGI) population. With funding support from CalOptima Health, Alianza Translatinx, a group that serves the TGI community, developed the report that showed TGI individuals face challenges, discrimination, and language and financial barriers with finding housing and staying housed in Orange County.
- On June 25, the Orange County Register published an article on the front page of the Local section about La Veta Village, an affordable housing project in Orange partially funded by CalOptima Health. A quote from my remarks at the groundbreaking event was included.

Fast Facts
August 2024

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

Membership Data* (as of June 30, 2024)

Total CalOptima Health Membership **919,052**

Program	Members
Medi-Cal	901,303
OneCare (HMO D-SNP)	17,253
Program of All-Inclusive Care for the Elderly (PACE)	496

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for 12 months ended June 30, 2024)

	YTD Actual	YTD Budget	Difference
Revenues	$5,368,374,569	$4,014,893,010	$1,353,481,559
Medical Expenses	$4,501,293,527	$3,785,719,951	($715,573,576)
Administrative Expenses	$230,780,376	$259,121,805	$28,341,429
Operating Margin	$636,300,666	($29,948,746)	$666,249,412
Medical Loss Ratio (MLR)	83.8%	94.3 %	(10.4%)
Administrative Loss Ratio (ALR)	4.3%	6.5%	2.2%

Note: Totals may not add due to rounding

Reserve Summary (as of June 30, 2024)

	Amount (in millions)
Board Designated Reserves	$1,005.9*
Statutory Designated Reserves	$131.9
Capital Assets (Net of depreciation)	$96.6
Resources Committed by the Board	$501.5
Board Approved Provider Rate Increases	$526.2
Resources Unallocated/Unassigned	$187.6*
Total Net Assets	$2,449.7

**Total of Board-designated reserves and unallocated resources can support approximately 113 days of CalOptima Health's current operations.*

Total Annual Budgeted Revenue **$4 Billion**

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

CalOptima Health Fast Facts

August 2024

Personnel Summary (as of July 31, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,316.3	77.35	41.01%	58.99%	5.55%
Supervisor	80	4	75%	25%	4.76%
Manager	116	3	66.67%	33.33%	2.52%
Director	67.75	1	100%	--%	1.45%
Executive	19	3	--%	100%	13.64%
Total FTE Count	1,599.1	88.4	47.89%	52.11%	5.24%

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

Provider Network Data (as of June 30, 2024)

	Number of Providers
Primary Care Providers	1,214
Specialists	10,153
Pharmacies	528
Acute and Rehab Hospitals	40
Community Health Centers	52
Long-Term Care Facilities	104

Treatment Authorizations (as of May 31, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	33.56 hours
Prior Authorization – Urgent	72 hours	18.34 hours
Prior Authorization – Routine	5 days	2.46 days

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

Member Demographics (as of June 30, 2024)

Member Age

0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference

English	54%
Spanish	31%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	38%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Fiscal Year 2024–25 Enacted State Budget

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» Next Steps

Background

On January 10, Gov. Gavin Newsom unveiled his Fiscal Year (FY) 2024–25 Proposed State Budget. With a spending plan of $291.5 billion ($223.6 billion General Fund [GF]), the governor predicted a budget deficit of $37.9 billion – about half the $68 billion initially projected by the Legislative Analyst's Office last year. Gov. Newsom attributed the past two years' shortfall to stock market declines in 2022, driving down revenue and delays in income tax collection. Most proposed budget solutions included reserve withdrawals, loans, fund shifts, and spending delays and deferrals.

To immediately address some of the budget deficit, the administration and California State Legislature attempted to minimize $17.3 billion of the overall shortfall by taking "early action" in April via a limited budget agreement that included some spending cuts that largely avoided health care programs.

Despite efforts in the early budget deal, revenues continued to come in below projections and further increase the deficit by an estimated $7 billion for a new remaining total of $27.6 billion. On May 10, Gov. Newsom released his May Revision to the Proposed State Budget, which largely reversed an agreement to fund Medi-Cal provider rate increases using Managed Care Organization (MCO) tax dollars. The May Revision also proposed several additional spending reductions to health care programs to address both the near-term budget deficit and look beyond FY 2024-25 in hopes of achieving positive operating reserves in the future. On May 29, leaders from both houses of the Legislature released a joint counterproposal to the May Revision, which would have instead delayed future rate increases funded by MCO tax revenues by one-year year from January 1, 2025, to January 1, 2026, rather than eliminate them. On June 13, the State Senate and State Assembly both passed its counterproposal (Assembly Bill [AB] 107) as a placeholder budget to meet the constitutional deadline while negotiations with the governor remained ongoing.

On June 22, Gov. Newsom and legislative leaders announced that a final budget agreement had been reached. After both houses of the Legislatures passed the agreed-upon budget revisions as Senate Bill (SB) 108 on June 26, Gov. Newsom signed both AB 107 and SB 108 into law. Additionally, the governor signed the MCO Tax Trailer Bill (AB 160) and consolidated Health Trailer Bill (SB 159) on June 29, containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2024-25 Enacted State Budget.

Back to Agenda

Fiscal Year 2024-25 Enacted State Budget *(continued)*

Overview

The final budget agreement includes obligations to support further resilience by adding financial protection so that the state doesn't overcommit anticipated revenues until it has been completely realized. The enacted budget eliminates the projected FY 2024-25 shortfall of approximately $45 billion and the FY 2025-26 shortfall of over $30 billion through a combination of spending cuts, fund shifts, delays, deferrals and reserves, including utilizing approximately half of the Rainy Day Fund over the next two budget years. Another goal of the final budget agreement is to strengthen the Rainy Day Fund by increasing the maximum limit from 10% to 20% of GF tax revenue, subject to future voter approval, and creating a new "Projected Surplus Temporary Holding Account."

The final Medi-Cal budget includes $161 billion ($35 billion GF) to cover a projected 14.5 million beneficiaries in FY 2024-25 – more than one-third of the state's population.

MCO Provider Tax

The FY 2024-25 Enacted Budget restores several MCO tax investments for future Medi-Cal provider rate increases that were proposed to be eliminated in the governor's May Revision. The final agreement includes $133 million in FY 2024-25, $728 million in FY 2025-26 and $1.2 billion in FY 2026-27 in addition to the approximately $300 million in provider rate increases that already became effective January 1, 2024, and will be maintained. However, total investments are less and partially redistributed compared with the original agreement reached with the MCO tax coalition last year. Some increases will still be effective on January 1, 2025, some will be delayed until January 1, 2026, and others have been eliminated. Additional provider types not included in the MCO tax coalition will now also receive a portion of the investments, further reducing total funding for the originally included provider types.

Effective **January 1, 2025**, Medi-Cal rate increases apply to:

- Emergency Department Physician Services ($100 million)
- Abortion Care and Family Planning ($90 million)
- Ground Emergency Medical Transportation ($50 million)
- Air Emergency Medical Transportation ($8 million)
- Community-Based Adult Services ($8 million)
- Congregate Living Health Facilities ($8 million)
- Pediatric Day Health Centers ($3 million)
- Community Health Workers to achieve 100 percent of Medicare rate

Effective **January 1, 2026**, Medi-Cal rate increases apply to:

- Physician/Non-Physician Professional Health Services ($753 million)
  - Evaluation & Management Codes for Primary Care and Specialist Office Visits, Preventative Services and Care Management (95% of Medicare rate)
  - Obstetric Services (95% of Medicare rate)
  - Non-Specialty Mental Health Services (87.5% of Medicare rate)
  - Vaccine Administration (87.5% of Medicare rate)
  - Vision (Optometric Services (87.5% of Medicare rate)
  - Other Evaluation & Management Codes (80% of Medicare rate)
  - Other Procedure Codes commonly utilized by Primary Care, Specialist and Emergency Department Providers (80% of Medicare rate)
- Private Duty Nursing ($62 million)
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) ($50 million)
- Non-Emergency Medical Transportation ($25 million)

The final agreement allows the California Department of Health Care Services (DHCS) to develop specific rate increase methodologies and supplemental payment amounts, particularly for 2025 investments.

Additional MCO tax investments include $145.4 million in FY 2024-25 to sustain Proposition 56-funded payments to address revenue decline and $40 million in FY 2026-27 for Medi-Cal workforce development through the California Department of Health Care Access and Information (HCAI). The final agreement also includes funding to enact continuous Medi-Cal eligibility for children 0-5, effective January 1, 2026. Notably, if Proposition 35 ("Protect Access to Care" MCO Tax Initiative) is approved by voters in the November 5, 2024, general election, the aforementioned provisions relating to the MCO provider tax will be inoperable since both are not financially sustainable.

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Fiscal Year 2024-25 Enacted State Budget *(continued)*

CalOptima Health Budget and Provider Rate Increase

CalOptima Health developed our proposed FY 2024-25 operating budget factoring in assumptions related to Medi-Cal program and policy changes, including the state budget. On May 2, the CalOptima Health Board of Directors approved an investment of **$526 million** to increase rates paid to delegated networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers. It is the largest provider rate increase of its kind in our nearly 30-year history. This unprecedented investment is intended to support timely access to critical health care services for members and promote longer-term financial stability of the managed care network over a 30-month period from July 2024 to December 2026. The uncertain nature of the state budget negotiations underscores why CalOptima Health's action to deliver our own separate provider rate increase is so significant.

Continuing Priorities in Medi-Cal

The enacted state budget continues to reflect funding for Medi-Cal benefits that were initially proposed to be eliminated in the May Revision. Key investments that have been protected include but are not limited to:

- Full-scope Medi-Cal coverage and In-Home Supportive Services (IHSS) for all ages, regardless of immigration status.
- **Adult Acupuncture** as a Medi-Cal covered benefit.
- Continued funding for **Health Enrollment Navigators** at clinics, but not at other entities. This does not impact CalOptima Health's own reserve-funded grants for community enrollers.
- **Free Clinics Augmentation** funding.
- Nearly all funding for the **Multifamily Housing Program**.

In addition, the final budget includes $230 million ($115 million GF) for a new directed payment program for children's hospitals to support critically ill children.

Significant Adjustments to Programs

To address the projected budget shortfall, the final budget includes several adjustments in the form of delays, triggers and reductions to certain programs and legislation that has not been implemented. Key program adjustments include but are not limited to:

- $39 million savings in the **Naloxone Distribution Project** from lower naloxone drug costs due to Medi-Cal Rx, while adding $8.3 million in special funds to expand the distribution of naloxone. This does not impact CalOptima Health's own reserve-funded naloxone distribution initiative.
- Reduced funding for **Equity and Practice Transformation (EPT) Program** payments by $111.3 million, which will eliminate the remaining funding for the program but preserve funding previously included in the 2022 Budget Act.
- Reverts all unexpended funds for the **Clinic Workforce Stabilization & Retention Payment Program**.
- Reduces or eliminates funding for several elements of the **Children and Youth Behavioral Health Initiative** (CYBHI), as follows:
  - Eliminates funding for school-linked partnership and capacity grants for community colleges, University of California and California State University systems.
  - Eliminates funding for the services and supports platform.
  - Reduces funding for the public education and change campaign.
  - Allows school districts to use a third-party administrator and/or managed care plans directly for billing related to the school-linked fee schedule.
  - Despite overall reductions, allocates new funding to establish the **wellness coach** benefit, effective January 1, 2025, to provide wellness promotion, education, screening, care coordination, individual and group support, and crisis referral in school-linked settings and across the Medi-Cal behavioral health delivery system.
- Reduces some funding for state and local public health.
- Reverts $450.7 million from the last round of the **Behavioral Health Continuum Infrastructure Program**, which leaves $1.75 billion to support existing projects.
- Reduces and delays funding for **Behavioral Health Bridge Housing** by one year from FY 2024-25 until FY 2025-26.
- Ends continued funding for the **Medication Assisted Treatment** program, which funds startup grants for new treatment facilities.

Fiscal Year 2024-25 Enacted State Budget *(continued)*

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that passed legislation.

About CalOptima Health

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

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

Student Behavioral Health Incentive Program (SBHIP) Progress Report – July 2024

Background

Serving public school children in grades TK–12, SBHIP was created by state law and is being implemented by the Department of Health Care Services (DHCS) over three years (January 1, 2022–December 31, 2024). Medi-Cal managed care plans across California are eligible for up to $389 million in incentive payments for developing programs that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers and meeting performance metrics associated with these programs. CalOptima Health has been allocated $25 million.

Under the leadership of Carmen Katsarov, LPCC, CCM, Executive Director of Behavioral Health Integration, CalOptima Health has led the collaborative work with our SBHIP partners, including:

- Orange County Department of Education (OCDE) and all 29 Orange County public school districts
- Hazel Health
- CHOC
- Western Youth Services
- Orange County Health Care Agency

SBHIP Objectives

As part of participating in SBHIP, CalOptima Health is following the DHCS-defined objectives as we work alongside our partners to increase behavioral health staff, build capacity and add behavioral health infrastructure in schools. The SBHIP objectives are:

1. Breakdown silos and improve coordination of child and adolescent behavioral health services for those enrolled in Medi-Cal through increased communication with schools, school-affiliated programs, managed care providers, counties and mental health providers.
2. Address health equity gaps as well as inequalities and disparities in access to behavioral health services.
3. Increase the number of TK–12 students enrolled in Medi-Cal receiving behavioral health services provided by schools, school-affiliated providers, the county behavioral health department and county offices of education.
4. Increase non-specialty services on or near school campuses.

Program Status

In May 2023, the CalOptima Health Board of Directors approved the SBHIP funding plan and the associated programs to be implemented by our partner organizations. Over the past 14 months, work has progressed rapidly, and CalOptima Health has met DHCS milestones for reporting progress thus far. Please see the next page for key accomplishments by our partners to date.

SBHIP Partner Accomplishments

OCDE and All 29 Orange County School Districts

- Expanded behavioral health staff in 22 of the 29 school districts, resulting in an overall 17% increase in staffing across those districts combined.
- Planned the 2024 School-Based Mental Health Summit, themed "Cultivating Joy: Nurturing Emotional Wellness & Happiness," taking place August 22, 2024.

Hazel Health

- Established a partnership with OCDE in January 2024, providing Hazel Health expertise as the largest telehealth solution offering online behavioral health services for K–12 schools.
- Launched Hazel's Heart Program (telehealth counseling services for students at school or home) in 20 of the 29 Orange County public school districts, resulting in 296,850 students at 357 school campuses having access to telehealth services. In the first six months of operation, nearly 900 care inquiries were logged.

CHOC

- Opened the first of 10 SBHIP-funded WellSpaces at Marco Forster Middle School in the Capistrano Unified School District on May 3, 2024. The remaining nine SBHIP-funded WellSpaces are scheduled to open by yearend.
- Expanded SBHIP-funded services delivered by CHOC's Mental Health Crisis Clinic to encompass a short-term stabilization program. The program provides a bridge from emergency care to outpatient care.
- Implemented a School Reintegration Program, a service that helps children transition back to school after a mental health crisis. With family consent, this program served 101 children between March and May 2024.
- Hired a psychologist who is providing consultative support for the deaf and hard of hearing program. The psychologist is developing training for CHOC providers to increase knowledge of best practices for serving youth who are deaf and hard of hearing and is offering no-cost consultative services for schools for the deaf and other educational programs serving this population.
- Developing a pilot program, Autism Comprehensive Care Program, to serve students between the ages of 12–17 with autism and acute/severe mental health concerns, such as depression, suicidal ideation, anxiety, etc. The pilot is projected to start in fourth quarter of 2024.

Western Youth Services

- Designing on-demand school-based mental health training modules to be accessible through a learning management system. Launching late July 2024, the library and training will encompass workshops covering the topics that the school districts identified as areas of need, including but not limited to:
  - Chill Skills – Stress Busters for Kids and Teens
  - Creating Safe Schools and Spaces for LGBTQIA+ Youth
  - Exploring Mindfulness
  - Triage, Coordination and Tiered Support: Optimizing Data-Driven Mental Health Services in Schools
  - Empowering Practical Cognitive Behavioral Techniques

  WYS will also provide ongoing consultative support to schools' behavioral health staff.

Orange County Health Care Agency (HCA)

- Selected an external platform, CHORUS, to improve data exchange among CalOptima Health, HCA and the county Mental Health Plan. CalOptima Health and HCA staff conduct the screenings and enter the information into CHORUS, enabling viewing of the referral information in real time and leading to more efficient care for CalOptima Health members.

Board of Directors Meeting
August 1, 2024

Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on June 13, 2024 to discuss topics of mutual interest.

The committees taking separate votes approved their recommended slate of candidates from the yearly recruitment initiative and have forwarded these recommendations to the Board for appointment. MAC said farewell to Ileana Soto-Welty who served as the Behavioral/Mental Health Representative and said farewell to Tina Bloomer, WHNP who served as the Nurse Representative and Junie Lazo-Pearson, Ph.D. who served as the Behavioral/Mental Health Representative.

Cheryl Meronk, Director, Medicare Program Development, presented a comprehensive overview of CalOptima Health's OneCare Program reviewing the benefits of having Medicare and Medi-Cal dual coverage. Ms. Meronk highlighted the current benefits available on this program and noted that OneCare was available to children with special needs who had aged out of California Children's Services and who met the Medicare guidelines required to join this program. Ms. Meronk responded to comments and questions from MAC and PAC members during her presentation.

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, provided an update on the CalAIM program and noted that CalOptima Health had launched all 14 community supports and contracted and on-boarded 73 providers and/or vendors for this program. She noted that CalOptima Health had provided approximately 48,000 members with community support services, housed over 1,000 members and eliminated a wait list for housing navigation services. Ms. Bruno-Nelson also discussed Enhanced Care Management, noting that over 5,000 CalOptima Health members were receiving services under this program. Ms. Bruno-Nelson answered questions on CalAIM services from various committee members.

Yunkyung Kim, Chief Operating Officer, thanked the MAC and PAC for their feedback on the draft strategic plan that was discussed at the April 11, 2024 meeting and asked that the committee members review the draft plan and continue to provide feedback as this is a work in progress and noted the importance of stakeholder input on CalOptima Health's strategic plan. Ms. Kim also notified the committees that new contract amendments have been mailed to providers that will have an impact on nearly every provider in CalOptima Health's delivery system. These contract amendments contain rate increases over a 30-month period totaling $526 million for nearly all provider categories. PAC Chair

Jena Jensen thanked CalOptima Health on behalf of the providers for always being there for providers during some difficult budget cycles.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, presented on how Measles and Pertussis are making a comeback and stressed the importance of vaccines. He noted that in 2023 there were 58 cases of the measles in the United States and that number in the first four months of 2024 measles cases had risen to 138. For Pertussis also known as Whooping Cough he noted that approximately 20 babies per year died in the United States between 2010 – 2020.

Michael Hunn, Chief Executive Officer, reviewed his CEO Report to the Board and thanked the members of both committees for their service on the MAC and PAC and their feedback on member care. Mr. Hunn also provided more information on the provider rates increase and his hopes of maintaining a stable network of providers for the next three-years.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS
June 6, 2024

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on June 6, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Chair Corwin called the meeting to order at 2:05 p.m., and Director Jose Mayorga led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Isabel Becerra, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Veronica Kelley (non-voting); Jose Mayorga, M.D.; Supervisor Vicente Sarmiento (arrived at 4:32 p.m.)

(All Board members in attendance participated in person)

Members Absent: Trieu Tran, M.D.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

The Clerk noted that staff would like to continue Agenda Item 25 to the August Board meeting. The Clerk also noted that there is one public comment request for prior to Agenda Item 1., Housing and Homelessness Incentive Program Round Three Check Presentations.

PRESENTATIONS/INTRODUCTIONS

One public comment was heard prior to the beginning of Agenda Item 1, which is noted under Public Comments.

1. Housing and Homelessness Incentive Program Round Three Check Presentations

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, invited Mr. Hunn and the Board members to please join representatives from each of the six organizations who were recipients of the Housing and Homelessness Incentive Program (HHIP) round three grant funding.

Ms. Bruno Nelson noted that in April-May 2024, the CalOptima Health Board approved nearly $36 million in community grants made possible by the HHIP and Board directed matching funds. In this third round of funding, CalOptima Health continues to strategically invest in its community by prioritizing three important areas, increasing transitional housing, encouraging innovation through countywide system change, and building the capacity of smaller organizations.

Ms. Bruno-Nelson introduced the six grantees:

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Hart Community Homes, Inc., which was granted $4 million to support the new construction of 20 units of transitional housing. This housing will assist 40 transitional age youth including those in extended foster care. Located in Fullerton, this site is next door to Hart Community Homes, Inc's job training café, and within walking distance to 14 community colleges, both of which will provide excellent resources the youth served.

The Illumination Foundation, which was granted $3.5 million for the purchase and rehabilitation of a facility to house family recuperative care located in Santa Ana. This first in the nation facility will provide beds for 30 individuals and families experiencing homelessness with a child exiting the hospital and in need of a place to recuperate.

Mind OC, which was granted $5 million for its Be Well Irvine campus to build 35 transitional housing units. This funding will help provide a continuum of care for individuals with behavioral health diagnoses residing on this campus.

Golden State Recuperative Care, Inc., which was granted $3.5 million for the purchase and rehabilitation of a facility to provide 30 recuperative care beds in Costa Mesa. Golden State Recuperative Care is a new recuperative care provider in Orange County and brings with them a history of excellent service provision.

Project HOPE Alliance, which was granted $2.1 million to develop, pilot, and train school staff on a new assessment tool to identify students experiencing homelessness. These students and their families will then be connected to available resources. These students are often referred to as the invisible homeless and this project aims to impact that reality across Orange County.

Mecca, a multi-ethnic collaborative of community agencies, was granted just over $2 million to develop, pilot, and train providers on a service model for older adults who are at risk of homelessness. With a focus on prevention, this program aims to identify older adults before they fall into homelessness and provide them with the support they need to remain home.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, started his report with a moment of silence to honor and respect one of CalOptima Health's staff. Alma, known as Patty Valencia, passed away a few weeks ago, and her memorial service was today. Mr. Hunn noted that he had the privilege of being able to attend the service with her family. Alma was a personal care coordinator and worked at CalOptima Health for nine years. Mr. Hunn added that he could only imagine how many families and individuals she had the privilege of touching through the work that she did in support of CalOptima Health's mission.

Mr. Hunn reviewed the Fast Facts data and reported that CalOptima Health currently serves about 928,000 individuals. CalOptima Health spends about 93% of every dollar on medical care, and 4.6% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $629.8 million; its capital assets are $96.1 million; its resources committed by the Board are $535.6 million; and its unallocated and unassigned resources are $682.3 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.9 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are about 1,600

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employees with a vacancy/turnover rate of about 6.04% as of the May 18, 2024, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has about 10,943 providers, 1,231 primary care providers, and 9,712 specialists; 528 pharmacies; 39 acute and rehab hospitals; 52 community health centers; and 104 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that the data is as of March 31, 2024. For urgent inpatient treatment authorizations, the average approval is within 34.18 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 19.78 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 2.37 days; the state-mandated response is 5 days.

Mr. Hunn also highlighted a few items from his CEO Report, which included the state budget, which as of now does not include cuts to healthcare, so the funding for CalOptima Health is secure. He also updated the Board on the California State Audit, noting that CalOptima Health just submitted its one-year update and there are no follow-up items at this time. Mr. Hunn also reported that CalOptima Health has had a lot of events this week, which included one at UC Irvine's Sue and Bill Gross School of Nursing on June 5, 2024, to present a workforce development check of $5 million dollars to their nursing program. He added that there was a press conference and an event by UCI to tour their education lab simulation. Dr. Mayorga, one of CalOptima Health's Board members and part of UC Irvine Healthcare, was in attendance and he may want to comment on the impact those workforce development dollars will have on UC Irvine's nursing students.

Director Mayorga thanked the Board, as well as the vision of the Board and the executives at CalOptima Health. Fundamentally, the impact of health care is going to be felt day in and day out because of the current shortage of health care workers. Director Mayorga added that this shortage is well-documented across every aspect of health care, which includes physicians and nurses, so the funding is well received by the School of Nursing at UC Irvine. He noted that what is unique about this is the funding is supporting a group of students who are absolutely committed and serving those individuals that are CalOptima Health members and its does not go unnoticed by them, that they are being trained in a county that is very forward thinking. Director Mayorga also noted that these nursing students want to serve the one in three people who live below the poverty level, and it is a wonderful testament to see the collaboration between a local health plan and an academic institution, to be forward thinking and training those who will be the future of Orange County's healthcare workforce.

Mr. Hunn commented that is it a privilege for CalOptima Health to go into the community and represent the great work that its Board has put forward. He added that CalOptima Health also contributed $1.3 million dollars on May 20, 2024, at the Santa Angelina event, which is a housing development in Placentia built by National CORE. Supervisor Chaffee attended that event and was at the property when Santa Angelina did the original groundbreaking for the 65 senior housing units that are on the site, along with the church that owns that property, and was willing to allow it to be developed. Mr. Hunn noted that Supervisor Chaffee may want to comment on that event.

Supervisor Chaffee noted that, as Mr. Hunn mentioned, the project in Placentia is for seniors and is beautifully laid out. He also noted that what he feels is important about the project is the example of a church making its surplus property available for affordable housing. Supervisor Chaffee added that hopefully it will encourage other churches to do the same thing, since there are several churches that have

surplus land.

Mr. Hunn concluded his report by announcing that CalOptima Health has been certified as a great place to work, which means, in a trust environment with its employees, that greater than 80% of employees are able to say, "I think CalOptima Health is a great place to work." He noted that CalOptima Health scored almost 25% higher than the national average. Mr. Hunn added that it is nice to have employees who are dedicated to the mission and the vision of what CalOptima health is about and dedicated every day to serving CalOptima Health members.

Director Contratto congratulated CalOptima Health for receiving the Great Place to Work Award certification, noting that she recalled when that award was originally created, the application was rigorous and difficult. She added that her guess is it is probably worse than when the awards started, and she was happy to be one of the first recipients of the Great Place to Work Award certification many years ago. Director Contratto also added that CalOptima Health has a remarkable team of people, and she is appreciative of leadership putting the work in to get that recognition.

3. Digital Transformation Update

Yunkyung Kim, Chief Operating Officer, provided an update on CalOptima Health's progress towards its digital transformation initiative. Ms. Kim reminded the Board and the public that back in March 2022 the Board authorized the creation of a digital transformation and workplace modernization strategy and invested $100 million dollars towards that effort. The Board authorized that initiative the same day that the Board approved CalOptima Health's updated mission and vision. Ms. Kim noted that staff and the Board realized that technology plays a critical role in CalOptima Health's ability to achieve its mission and vision for all customers. She also noted that as CalOptima Health developed and implemented this initiative, it kept four outcomes in mind for what it wanted to achieve, which are: (1) Member Experience: Seamless access to care, personalized support and communication to ensure members both are, and feel, cared for; (2) Provider Experience: Streamlined processes to enhance the delivery of quality care, enabling same day treatment authorizations and real time claims payments; (3) Employee Experience: Employees are equipped with the tools to succeed in delivering on the commitment to improved member and provider experience; and (4) Infrastructure & Governance: Secure, resilient and flexible infrastructure to support transformation, and alignment between the business, technology, and finance for ongoing transformation. Ms. Kim reviewed in detail the key milestones achieved in year one and year two. She also reviewed projects in process for year three.

Ms. Kim responded to Board member questions and comments.

PUBLIC COMMENTS

- Dr. Pooja Bhalla, CEO, Illumination Foundation: Oral report regarding expressing gratitude to the leadership and Board of CalOptima Health on behalf of children experiencing homelessness in Orange County.Vasila Ahmad, Office of Supervisor Sarmiento: Oral report regarding Agenda Item 27, noting that Supervisor Sarmiento is honored to be nominated for Vice Chair of the CalOptima Health Board.**CONSENT CALENDAR**

4. Minutes

a. Approve Minutes of the May 2, 2024, Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the February 15 2024 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

5. Adopt Resolution No. 24-0606-01 Authorizing and Directing Execution of Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

6. Adopt Resolution No. 24-0606-02 Approving and Adopting Updated CalOptima Health Human Resources Policies

7. Authorize Actions Related to CalOptima Health's Supplemental Retirement Plan

8. Approve Amended Policy for Election of Officers

9. Approve Actions Related to a Contract with Infomedia Group, Inc. dba Carenet Healthcare Services

10. Authorize Property Management Contract Amendment Related to the Garden Grove Street Medicine Support Center

11. Approve Contract for Federal Advocacy Services

12. Approve Actions Related to the Utilization Management Clinical Decision Criteria Application

13. Authorize the Chief Executive Officer to Execute an Amendment to the Contract with Kennaday Leavitt PC

14. Authorize a New Delegation Agreement for Claims Payment and Processing, Credentialing, and Utilization Management Delegated Responsibilities

15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023
Agenda Item 15 was pulled for a separate vote.

16. Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund

17. Receive and File:
  a. April 2024 Financial Summary
  b. Compliance Report
  c. Federal and State Legislative Advocates Reports
  d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 4 through 17, minus Agenda Item 15, as presented. (Motion carried; 7-0-0; Supervisor Sarmiento and Director Tran absent)***

15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023
Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors authorized the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2023 (IGT 13): 1.) Submission of a proposal to the California Department of Health Care Services to participate in IGT 13; 2.) Pursuit of funding partnerships with eligible participating entities; and 3.) The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek IGT 13 funds. (Motion carried; 6-0-0; Director Mayorga recused; Supervisor Sarmiento and Director Tran absent)***

REPORTS/DISCUSSION ITEMS

18. Approve the CalOptima Health Fiscal Year 2024-25 Operating Budget
Vice Chair Becerra, as Chair of the Finance and Audit Committee (FAC), provided introductory comments on the s (FY) 2024-25 Operating and Capital Budgets. She noted that the FAC reviewed the FY 2024-25 budgets in detail.

Nancy Huang, Chief Financial Officer, reviewed the FY 2024-25 Operating Budget noting that the projected revenue is approximately $4.3 billion, and the projected expenses (which includes administrative costs) is about $4.29 billion with an operating margin of about $240,000 dollars. She also noted that provider rate increases in this fiscal year would be funded by reserves. Ms. Huang reported that CalOptima Health is proposing a balanced budget for FY 2024-25. She provided a high-level overview of the budget details including enrollment, medical costs, and other non-operating costs.

Ms. Huang and Mr. Hunn responded to Board member comments and questions.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2024-25 Budget, as reflected in Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items; and 2.) Authorized the expenditures and appropriated the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing. (Motion carried; 7-0-0; Supervisor Sarmiento and Director Tran absent)***

19. Approve the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets

Ms. Huang reviewed the FY 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets and responded to Board members' comments and questions.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets; and 2.) Authorized the expenditures and appropriated the funds for the following items, which shall be procured in accordance with policies approved by the Board of Directors: a.) Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project; b.) Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project; and c.) Attachment A2: Update to the Digital Transformation Year One and Year Two Capital Budgets by Project. (Motion carried; 7-0-0; Supervisor Sarmiento and Director Tran absent)***

20. Authorize Amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts

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

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Contracts to: 1.) Update the Medi-Cal capitation rates for Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Networks, effective July 1, 2024; and 2.) Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024. (Motion carried; 6-0-0; Director Mayorga recused; Supervisor Sarmiento and Director Tran absent)***

Chair Corwin noted for the record that he would not be participating in Agenda Item 21 due to his affiliation with Pomona Valley Hospital and passed the gavel to Vice Chair Becerra.

21. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts

Chair Corwin did not participate in this item due to his affiliation with Pomona Valley Hospital. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts to: 1.) Update rates for inpatient hospital services when contracted at All Patients Refined Diagnosis Related Groups (APR-DRG)***

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rates, effective July 1, 2024; 2.) Update rates for certain outpatient hospital claims, effective July 1, 2024; and 3.) Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024. (Motion carried; 5-0-0; Chair Corwin and Director Mayorga recused; Supervisor Sarmiento and Director Tran absent)

Vice Chair Becerra passed the gavel back to Chair Corwin.

22. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Professional Services, Community Clinics, and Federally Qualified Health Centers Contracts

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

Note this item was re-read into the record and another vote was taken as there was not a voting quorum in the room at the time of the first reading and vote.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Contracts for: 1.) Professional Services: Update rates for Applied Behavior Analysis (ABA) providers, effective July 1, 2024; 2.) Professional Services, Community Clinics, and Federally Qualified Health Centers: Update rates for Specialist Professional services and California Children's Services paneled providers, effective July 1, 2024; 3.) Professional Services and Community Clinics: Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024; and 4.) Federally Qualified Health Centers: Update rates to no less than other contracted providers for similar targeted rate increase-eligible services, per federal requirements. (Motion carried; 5-0-0; Vice Chair Becerra and Director Mayorga recused; Supervisor Sarmiento and Director Tran absent)***

23. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts

This item was continued due to lack of a voting quorum.

24. Approve Actions Related to AltaMed Health Services Medi-Cal Contract

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the transition of the current Medi-Cal health network risk arrangement for AltaMed Health Services (AltaMed) from a Shared Risk Group to a Health Maintenance Organization; 2.) Authorized the Chief Executive Officer to execute a new HMO contract with AltaMed Health Network, Inc. for Medi-Cal, effective November 1, 2024, subject to approval by the Department of Managed Health Care;***

and 3.) Authorized unbudgeted expenditures in an amount up to $1.0 million from existing reserves to support the AltaMed Medi-Cal HMO contract for the period of November 1, 2024, through June 30, 2025. (Motion carried; 7-0-0; Supervisor Sarmiento and Director Tran absent)

25. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees
This item was continued to the August Board meeting.

26. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2024-25
After considerable discussion regarding the CalOptima Health meeting schedule for FY 2024-25, Supervisor Chaffee made the following amended motion:

No Action Taken: ***On motion of Supervisor Chaffee, seconded by Director Contratto, amended motion to approve the Fiscal Year 2024-25 meeting schedule and continue the organizational meeting until the September Board meeting. (Motion failed; 2-3-2; Supervisor Chaffee and Director Contratto voting yes; Vice Chair Becerra and Directors Byron and Mayorga voting no; Chair Corwin and Director García Guillén abstained; Supervisor Sarmiento and Director Tran absent)***

The Board then considered the original motion, which did not continue the organizational meeting.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors adopted the proposed meeting schedule of the CalOptima Health Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period of July 1, 2024, through June 30, 2025. (Motion carried; 7-0-0; Supervisor Sarmiento and Director Tran absent)***

27. Election of Officers of the Board of Directors for terms beginning July 1, 2024
The Board heard public comment on this item as noted under Public Comments.

Chair Corwin turned the election over to CalOptima Health Legal Counsel.

James Novello, Outside General Counsel, Kennaday Leavitt, read the nominations received in advance of the meeting as prescribed by the Board Election Policy:

- Director Byron nominates Chair Corwin for Chair and Vice Chair Becerra for Vice Chair.
- Vice Chair Becerra nominates herself for Chair and Director Contratto for Vice Chair.
- Director Contratto nominates Vice Chair Becerra for Chair and Supervisor Sarmiento for Vice Chair.
- Supervisor Sarmiento nominates Vice Chair Becerra for Chair and himself for Vice Chair.

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- Chair Corwin nominates Vice Chair Becerra for Chair and Director Mayorga for Vice Chair.

Mr. Novello queried the Board members who were nominated to see if anyone wanted to withdraw from the election:

- Chair Corwin stated he is withdrawing from the Chair election.

- Director Contratto stated she is withdrawing from the Vice Chair election.

Mr. Novello queried the Board members to see if there were any other nominations for Chair or Vice Chair.

Supervisor Chaffee stated that he nominates himself for Vice Chair.

The Board took a 10-minute recess at 3:44 p.m. to allow for changes to the ballots for Chair and Vice Chair.

The Board returned from recess at 3:54 p.m. and the Clerk distributed and collected the ballots for the Chair of the CalOptima Health Board.

The Clerk read the ballots into the record for the election of Chair as follows:

- Chair Corwin voted for Isabel Becerra as Chair.

- Director Contratto voted for Isabel Becerra as Chair.

- Vice Chair Becerra voted for Clayton Corwin as Chair.

- Supervisor Chaffee voted for Isabel Becerra as Chair.

- Director Mayorga voted for Isabel Becerra as Chair.

- Director Byron voted for Isabel Becerra as Chair.

- Director García Guillén voted for Isabel Becerra as Chair.

<u>Results for Chair Election:</u>
Isabel Becerra = 6 votes
Clayton Corwin = 1 vote

Mr. Novello congratulated Vice Chair Becerra, who will be the new Chair of the CalOptima Health Board effective July 1, 2024.

Mr. Novello stated that ballots for the election of Vice Chair would now be distributed. He reminded the Board that there are multiple candidates and if a quorum is not achieved, which is five votes for a single candidate, within three rounds of voting, voting would stop and the person with the least votes would be

dropped from the ballot continue voting until a quorum is achieved.

The Clerk distributed and collected the first round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Supervisor Chaffee voted for himself for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.
- Director Byron voted for Jose Mayorga for Vice Chair.

Results for Vice Chair Election Round One:
Vicente Sarmiento = 3
Jose Mayorga = 3
Doug Chaffee = 1

The Clerk distributed and collected the second round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Director Byron voted for Jose Mayorga for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Supervisor Chaffee voted for himself for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.

Results for Vice Chair Election Round Two:
Vicente Sarmiento = 3
Jose Mayorga = 3
Doug Chaffee = 1

The Clerk distributed and collected the third round of ballots for Vice Chair of the CalOptima Health

Board and read the following results into the record:

- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Supervisor Chaffee voted for Jose Mayorga for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.
- Director Byron voted for Jose Mayorga for Vice Chair.

Results for Vice Chair Election Round Three:
Vicente Sarmiento = 3
Jose Mayorga = 4

The Clerk distributed and collected the fourth round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Director Byron voted for Jose Mayorga for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.
- Supervisor Chaffee voted for Jose Mayorga for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.

Results for Vice Chair Election Round Four:
Vicente Sarmiento = 3
Jose Mayorga = 4

Mr. Novello noted that the voting continues until there are five votes for a single candidate.

Director Contratto asked if the Board Election Policy could be pulled and read it into the record so everyone is clear on the requirements.

Ms. Kim, Chief Operating Officer, pulled up the policy and read the following into the record:

"The clerk will distribute the ballots immediately prior to the vote, collect the ballots once completed by the directors, count the ballots and announce the results on the record. Voting shall be repeated as many times as necessary to obtain the required majority vote for any nominee for the board officer position. The clerk will read the results of each vote and the vote of every director into the record. If an election does not result in a nominee receiving the required five votes. After three ballots for each subsequent vote, the nominee with the fewest number of votes from the previous tally shall be removed from the ballot prior to the next vote at that same meeting. This procedure shall continue until there are only two nominees remaining, in no event shall a name be struck from the ballot that leaves a ballot with only one remaining nominee."

The Clerk distributed and collected the fifth round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Supervisor Chaffee voted for Jose Mayorga for Vice Chair.
- Director Byron voted for Jose Mayorga for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.

<u>Results for Vice Chair Election Round Five:</u>
Vicente Sarmiento = 3
Jose Mayorga = 4

The Clerk distributed and collected the sixth round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Supervisor Chaffee voted for Jose Mayorga for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.

- Director Byron voted for Jose Mayorga for Vice Chair.

Results for Vice Chair Election Round Six:
Vicente Sarmiento = 3
Jose Mayorga = 4

After discussion on whether to continue the election of Vice Chair to the August Board meeting, after hearing that Supervisor Sarmiento was close by and could join the Board meeting, the Board took the following action:

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors agreed to take a recess at 4:21 p.m. to allow Supervisor Sarmiento to join the meeting. (Motion carried: 7-0-0; Supervisor Sarmiento and Director Tran absent)***

Supervisor Sarmiento arrived at 4:32 p.m.

Mr. Novello noted that the Board could now hear Agenda Item 23 as a voting quorum could be reached with Supervisor Sarmiento in attendance.

23. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts
Vice Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Director García Guillén did not participate in this item due to potential conflicts of interest. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts to: 1.) Update rates for certain Ancillary Services Providers including, Ambulatory Surgery Centers, Home Health Agencies, Community Based Adult Services Centers, Free Standing Clinical Laboratories, Enhanced Care Management Providers, and Short-Stay Skilled Nursing Facilities, effective July 1, 2024; 2.) Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024; and 3.) Add language to implement requirements in Department of Health Care Services All Plan Letter 23-004 for Skilled Nursing Facilities – Short Stays, and adjust payments, effective January 1, 2023, through June 30, 2024. (Motion carried; 5-0-0; Vice Chair Becerra and Directors García Guillén and Mayorga recused; Director Tran absent)***

The Board resumed voting for Agenda Item 27.

27. Election of Officers of the Board of Directors for terms beginning July 1, 2024

Supervisor Sarmiento commented on the reason he was not at the meeting earlier is because today was his daughter's graduation, and she was in car accident. So now he and his wife were able to make sure his daughter was not seriously injured. He is here at the meeting. He noted that he understands there are now two of us that are being considered for Vice Chair and he have tremendous respect for Director Mayorga, and congratulated Chair-elect Becerra. Supervisor Sarmiento noted that his only concern is that without knowing who will be reappointed to the CalOptima Health Board, for continuity on the Board and for CalOptima Health, it would be wise to have a supervisor as one of the officers elected on the Board.

The Clerk distributed and collected the seventh round of ballots for Vice Chair of the CalOptima Health Board and read the following results into the record:

- Chair Corwin voted for Jose Mayorga for Vice Chair.
- Vice Chair Becerra voted for Vicente Sarmiento for Vice Chair.
- Director Mayorga voted for himself for Vice Chair.
- Director García Guillén voted for Vicente Sarmiento for Vice Chair.
- Director Byron voted for Jose Mayorga for Vice Chair.
- Director Contratto voted for Vicente Sarmiento for Vice Chair.
- Supervisor Sarmiento voted for himself for Vice Chair.
- Supervisor Chaffee voted for Supervisor Sarmiento for Vice Chair.

<u>Results for Vice Chair Election Round Seven:</u>
Vicente Sarmiento = 5
Jose Mayorga = 3

Chair Corwin congratulated both Chair-elect Becerra and Vice Chair-elect Sarmiento, noting that the agency is in capable hands. He also thanked everyone for their patience in the election process.

Chair Corwin noted that before getting to Board Member Comments he is creating a Board Ad Hoc Committee to really focus on an open issue CalOptima Health has had for a few months, which is further analysis and evaluation of appropriate levels of executive compensation. The Board will recall that the executive compensation was deferred from the general compensation adjustments made earlier this year. Chair Corwin added that the executive performance reviews and guidelines need to be further evaluated. He appointed Director Becerra, Director Contratto, and Supervisor Sarmiento to serve on the Ad Hoc Committee, with Director Becerra serving as Chair of the Ad Hoc Committee.

<u>BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS</u>
Director Becerra commented that it is an incredible privilege, not just for the Chair elect consideration, but just to be on the Board. This is a very significant stakeholder organization in Orange County that is leading the charge and making sure that the underserved and those most in need, get the medical care

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they need on time by the right provider receiving the right kind of service. And being a part of the governance of this organization is a huge privilege. She noted that she does not take it lightly. She commended her colleagues and the staff and legal counsel for helping the Board put together a process that is defendable, that is transparent, that everyone feels comfortable with.

Director Contratto noted that the reason that the Board did not ask a lot of questions about the budget is because each member gets so incredibly well briefed. It is amazing the amount of detail that goes in, but then the way it is presented to the Directors is clear and concise. She noted that the Board members have many questions during the FAC and during the briefings and there is not one question that staff cannot answer. Director Contratto added that CalOptima Health's budgeting process is probably the best budgeting process she has ever been through, and it is a $4 billion dollar organization. She also added that she wants everyone out there to know the Board members separately ask a lot of questions before they get to the meeting.

Director Mayorga echoed Director Contratto's comments and added that one of the critical elements in his discussion with Ms. Huang was how can CalOptima Health protect its hospital partners and the actual folks on the ground seeing patients. CalOptima Health gave clinicians the assurance that it is going to continue to support them in their efforts to care for its members. So, Director Mayorga thanked and commended the executive leaders, obviously, the CalOptima Health finance team, and the Board for approving the budget and noted the rate increases goa long way. Lastly, as a physician, executive, and someone who has cared for this population for the last 19 years, Director Mayorga noted that he has seen that CalOptima Health really takes the members' care seriously. Director Mayorga noted it is an honor and privilege to be here.

Supervisor Sarmiento congratulated Vice Chair Becerra for being elected as Chair of the CalOptima Health Board. He also thanked the Board for supporting his election as Vice Chair. Supervisor Sarmiento noted that this Board has done amazing things in support of CalOptima Health's providers and members and now with the recent governance changes and expectations of the Board being engaged he sees a positive future. He added that he hopes this momentum takes the Board into the next term and a half and that CalOptima Health and its Board continues to ensure quality health care for the members it serves.

Chair Corwin thanked his colleagues for the privilege of being Chair and for the support and education he has received from the members of the Board. He noted that it has been an honor to serve on the CalOptima Health Board.

Mr. Hunn commented that CalOptima Health is investing in more innovative programs than most other public health plans across the state. That innovation cannot happen without real collaboration between management and the Board, and it cannot happen unless there are dedicated Board members who are willing to immerse themselves not only in the operational components of what it takes to run a full blown health plan, serving a million people with a $4.3 billion budget, but also being able to guide and direct both the policy and the fiscal work to take the monies entrusted to the organization, the tax dollars, and to make sure those dollars get to the right place at the right time for the folks that need it and are entitled to receive it. Mr. Hunn thanked the Board and noted that he believes that most people who apply to be on CalOptima Health's Board do not understand the number of hours that they will spend in briefings, the hours and work that goes into reading the various committee and the Board materials. Mr. Hunn added that from a governance standpoint, this is the first Board since 1994, when CalOptima Health was created as a public agency, that has taken on governance, inclusive of member terms, policies, procedures, elections, and strove to figure out a better process.

It may have sounded like there are a lot of moving parts here, but it is the implementation of new policies that the Board has adopted. Mr. Hunn provided background on how CalOptima Health was created and why it was created as well as how the state and various county agencies determine if a member qualifies for Medi-Cal and then CalOptima Health takes it from there. Mr. Hunn noted that CalOptima Health is a public agency and although it is in Orange County and established by a county ordinance, it is not a department in the county. CalOptima Health is a separate public agency, and the directors who make up CalOptima Health's Board are a separate fiduciary body that establishes budgets, policy, and spending. Mr. Hunn added that none of CalOptima Health's budget comes from the county, it comes from state and federal dollars. Many people may be asking why the Orange County Board of Supervisors appoints CalOptima Health Board Members and the answer is that when the ordinance was written that established CalOptima Health as a public agency, the right to appoint the Board remained at the county with the Board of Supervisors. So, on a calendar every four years, there is an opportunity for the then sitting Board of Supervisors to reappoint and/or appoint members to this public agency Board, because CalOptima Health resides inside the ordinance that was established back in 1993. At today's meeting the CalOptima Health Board of Directors, operating under its Bylaws, appointed its officers and will guide and direct the work of this public agency. Mr. Hunn thanked each Board member for the work that they undertake and hopefully those listening in will have a better understanding of how CalOptima Health is legally structured and the governance its Board operates under.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 4:57 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 1, 2024

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 13, 2024

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on March 13, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Trieu Tran called the meeting to order at 3:05 p.m., welcomed Maura Byron to the Committee, and asked Director Byron to lead the Pledge of Allegiance.

CALL TO ORDER

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

Members Absent: José Mayorga, M.D.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed the Chief Medical Officer Report with the Committee and started off by providing an update on the Jiva project. Dr. Pitts noted that Jiva, CalOptima Health's care management program, successfully went live on February 1, 2024. He thanked staff for their hard work to meet the target go-live date, noting that approximately 310 million records were transferred from Guiding Care, CalOptima Health's previous care management program, into the new Jiva platform.

Dr. Pitts also provided an update on the Skilled Nursing Facilities (SNF) Access Program. He noted that the purpose of CalOptima Health's SNF Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care. Dr. Pitts reported that as of December 2023, CalOptima Health has 68 actively contracted SNFs in Orange County (out of 72 SNFs), 32 SNFs contracted out-of-county, and 16 contracts in progress for both in and out-of-county.

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Dr. Pitts responded to Committee member questions.

PUBLIC COMMENTS
David Robertson, Empathy Now: Oral report regarding Agenda Items 3 and 5.

CONSENT CALENDAR
2. Approve the Minutes of the December 13, 2023, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORT/DISCUSSION ITEMS
3. Receive and File 2023 CalOptima Health Quality Improvement Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan
Linda Lee, Executive Director, Quality Improvement, presented the 2023 annual evaluation of CalOptima Health's Quality Improvement (QI) Program. She started with the achievements, noting that in September 2023, for the nineth year in a row, CalOptima Health was among the top performers. Ms. Lee also reported that two community-based organizations honored CalOptima Health for its work in serving vulnerable populations. Community Action Partnership of Orange County presented CalOptima Health with a Community Hero Award for its work on housing and food security, and the Ely Home presented CalOptima Health with a Humanitarian Award for its contributions to serving abused and unhoused children and families. Ms. Lee reported on the many awards that CalOptima Health and its leadership received in 2023.

Ms. Lee reviewed the 2023 priority goals and accomplishments. Priority Goal 1: Developing CalOptima Health's Health Equity Framework. The accomplishments for Priority Goal 1 included developing the framework that begins with assessing organizational readiness and included several milestones to implement interventions, plan activities, and track progress. Priority Goal 2: Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare. The accomplishments for Priority Goal 2 included receiving a four out of five in the NCQA Medicaid Health Plan Ratings in 2023 and receiving an overall Three-Star Rating for Medicare (OneCare). Priority Goal 3: Engage providers through the provision of Pay for Value (P4V) Programs for Medi-Cal, OneCare, and Hospital Quality. The accomplishments for Priority Goal 3 for P4V included generating monthly prospective rate reports for Health Networks (HNs) and CalOptima Health Community Network Clinics; sharing HN report cards with HNs; issuing P4V payment checks in Q4 2023; and adopting the Integrated Healthcare Association (IHA) pay for performance methodology, which aligns with Department of Health Care Services (DHCS) Managed Medi-Cal Accountability for Medi-Cal and CMS Star measures for OneCare. Accomplishments for the P4V Hospital Quality Program in Priority Goal 3 included developing and distributing to each contracted hospital baseline scorecards indicating hospital performance for measure year 2022.

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Ms. Lee reviewed the 2023 QI Evaluation highlights regarding program structure and oversight, program initiatives, performance outcomes, member experience, and patient safety. Ms. Lee also reviewed the recommendations for 2024 based on the 2023 QI Evaluation, which included collaborating with external stakeholders and partners in comprehensive assessments of members; enhancing member and provider data collection to ensure the practitioner network can meet member cultural and linguistic needs; incorporating feedback provided by members and network providers in the design, planning, and implementation of CalOptima Health's continuous quality improvement activities, focusing on access to care; incorporating social determinants of health factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs; and strategizing and streamlining member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, interactive voice response calls, mobile texting, targeted social media campaigns and robocall technology.

Ms. Lee reviewed in detail the 2024 QI Program and Work Plan, including the following priority areas: Maternal Health; Children's Preventive Care; Behavioral Health Care; and Program Goals. She also highlighted the revisions for 2024, including incorporating a health equity focus into the QI Program, now named Quality Improvement and Health Equity Transformation Program (QIHETP). CalOptima Health updated priority areas and goals, updated sections in the QIHETP to reflect current operational processes and workflows for NCQA accreditation, grievance and appeals, and encounter data review. Ms. Lee reviewed the updated program staffing and resources to reflect the current organizational structure, which included adding a Chief Health Equity Officer, adding additional Medical Directors to support a medical model, adding a Director, Medicare Stars and Quality Initiatives, and adding a Director, Medicare Programs. She also reviewed in detail the 2024 annual work plan focus areas as well as revisions in the 2024 program structure and oversight, quality of clinical care, and quality of service and safety of clinical care.

Ms. Lee and Michael Hunn, Chief Executive Officer, responded to Committee members' questions and comments.

CalOptima Health received public comment from Dave Robertson, Empathy Now on this item.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended that the Board of Directors receive and file the 2023 CalOptima Health Quality Improvement Evaluation, and recommend the Board of Directors approve the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan. n. (Motion carried 2-0-0; Director Mayorga absent)***

4. Recommend that the Board of Directors Approve the 2023 CalOptima Health Utilization Management Program Evaluation and the 2024 CalOptima Health Integrated Utilization Management/Case Management Program Description

Kelly Giardina, Executive Director, Clinical Operations, reviewed the 2023 CalOptima Health Utilization Management (UM) Program Evaluation, noting that the lookback period was the fourth quarter of 2022 through the third quarter of 2023. Ms. Giardina also noted that the UM program description is revised each year based on the previous year's evaluation to ensure ongoing alignment

with evolving healthcare standards and to optimize UM performance. Ms. Giardina reviewed the accomplishments for the lookback period, which included adding Medical Directors with expertise in internal medicine, emergency medicine and trauma, child/adolescent psychiatry and pharmacy, and family addiction medicine. Additional accomplishments included improved reporting and workflows to prioritize treatment authorization to exceed turnaround time; provider portal enhancements and the design, configuration, and preparation for the new medical management clinical documentation platform Jiva, which went live in February 2024. Ms. Giardina reviewed other improvements and enhancements in the 2023 UM Program Evaluation, which included, refinement of hospital utilization measurement, including bed days goals; launched a brain/spine/pain care coordination workgroup; continuity-of-care protocol refinements, and transplant program enhancements. Ms. Giardina reported in detail key takeaways of the 2023 UM Program Evaluation, including areas of focus and opportunities for improvement.

Stacie Oakley, RN, Director, Utilization Management, reviewed the 2024 UM Program goals and initiatives based on the outcomes of the 2023 UM Program Evaluation. Ms. Oakley noted the goal of the UM program is to manage appropriate utilization of medically necessary covered services to ensure access to quality and cost-effective health care for CalOptima Health members through timely and efficient treatment authorizations; coordination and continuity of care; support of members through transition of care, including addressing complex discharge needs; oversight and support of access, availability, and timeliness of care; member and provider satisfaction; identifying and addressing over and under-utilization of care; and the promotion of health literacy, prevention and improved member outcomes. She reported that CalOptima Health's integration of Quality Program Initiatives, such as the Comprehensive Community Cancer Screening and Support Program that was launched in January 2023 and the five-year Hospital Quality Program (2023-2027), are designed to improve member quality of care through early detection of cancers and increased patient safety efforts through performance-driven processes. Ms. Oakley also reported that CalOptima Health and DHCS combined strategic goals for maternal health, children's preventive care, and behavioral health care, providing details of the combined strategic goals. She also reviewed various topics discussed at the CalOptima HN Forums, where HNs and CalOptima Health have joint discussions on programmatic enhancements and changes to the implementation and operation of medical management programs. Ms. Oakley also reviewed the various UM sub-workgroups created to ensure member needs are addressed on a timely basis to produce the best outcomes.

Ms. Giardina and Mr. Hunn responded to Committee members' questions and comments and provided additional details.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended Board of Directors' approval of the 2023 CalOptima Health Utilization Management Program Evaluation, and recommended Board of Directors' approval of the 2024 CalOptima Health Integrated Utilization Management and Case Management Program Description. (Motion carried 2-0-0; Director Mayorga absent)***

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5. Receive and File 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Donna Frisch, M.D., PACE Medical Director, presented the 2023 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation and the CalOptima Health PACE QI Plan for 2024. Dr. Frisch started with the PACE accomplishments for 2023, which included maintaining all guidance through the end of the COVID-19 Public Health Emergency and PACE's collaboration with CalOptima Health Long Term Support Services (LTSS) to significantly reduce the number of PACE participants residing in long-term care facilities. She also shared that PACE had an 89% influenza and 93.5% pneumococcal immunization rates by the fourth quarter of 2023. For quality of diabetes care, 89% of the annual eye exams were completed and 100% of nephropathy monitoring of diabetic members. Dr. Frisch also shared that CalOptima Health had a rate of 100% medication reconciliation within 10 days following a hospital or skilled nursing discharge and 96% of PACE participants had a Physician's Order for Life-sustaining Treatment (POLST) completed. She added that the CalOptima Health PACE overall participant satisfaction score was 94% compared to the national average of 88.6% and the CalPACE score of 89%. Dr. Frisch reviewed PACE workplan elements and scores achieved in 2023. She also reviewed in detail the opportunities for improvement in 2024.

Dr. Frisch and Mr. Hunn responded to Committee members' questions and comments and provided additional details regarding the PACE QI Plan.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended that the Board of Directors' Receive and File the 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation, and recommended that the CalOptima Health Board of Directors approve the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan. (Motion carried 2-0-0; Director Mayorga absent)***

6. Recommend that the Board of Directors Approve Recommendation for Vice Chair Appointment to the Whole-Child Model Family Advisory Committee

Yunkyung Kim, Chief Operating Officer, introduced this item.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors approve the appointment of Erika Jewell as the Vice Chair to fulfill a remaining term through June 30, 2025 as recommended by the Whole-Child Model Family Advisory Committee. (Motion carried 2-0-0; Director Mayorga absent)***

ADVISORY COMMITTEE UPDATES

Chair Tran noted that the Advisory Committee Updates for Agenda Items 7 and 8 were in the meeting materials, unless there were questions from Committee members.

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7. Program of All-Inclusive Care for the Elderly Members Advisory Committee Update

8. Whole-Child Model Family Advisory Committee Report

INFORMATION ITEMS

9. Applied Behavior Analysis and Behavioral Health Pay-for-Value Program
Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, provided an overview of the Applied Behavior Analysis (ABA) and Behavioral Health (BH) P4V Programs. By way of background, Ms. Katsarov reviewed the previous ABA P4V Program timeframe, which was January 2, 2021, to December 31, 2022, with the P4V Program Evaluation taking place between December 2022 and March 2023. CalOptima Health contracted with an ABA consultant who met with ABA providers during that time and learned that CalOptima Health needed a clearer understanding of the data used, more frequent payouts of incentive dollars, and to increase collaboration. Ms. Katsarov reviewed in detail the new ABA P4V Program elements, including the target percentage and the weighting of those targets. She also reviewed the program methodology, which included data collection, measurement and scoring methodology, the provider attestation form, the care experience digital parent survey, and the measurement period and payout. Ms. Katsarov noted that providers will be able to earn up to 10% of the paid claims during each measurement period by achieving any or all the program elements. She also reviewed in detail the BH P4V methodology, including measurement set and benchmarks, as well as the measurement period and payout.

Ms. Katsarov responded to Committee members' questions and comments.

The following items were accepted as presented.

10. Quarterly Reports to the Quality Assurance Committee

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

COMMITTEE MEMBER COMMENTS

The Committee members thanked staff for the work that went into preparing for the meeting.

ADJOURNMENT

Hearing no further business, Chair Tran adjourned the meeting at 4:57 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 12, 2024

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

4. Approve the Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Contacts

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Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Actions

Approve the revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan.

Background

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and customer service provided to its members, which aligns with CalOptima Health's vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The QIHETP is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks.

CalOptima Health's QIHETP is reviewed, evaluated, and approved annually by the Board of Directors. The QIHETP defines the structure within which quality improvement (QI) and health equity activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

Discussion

CalOptima Health staff has revised the 2024 QIHETP and Workplan to ensure that it is aligned with health equity and cultural linguistic improvement efforts and requirements. This will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) Health Plan and Health Equity accreditation standards are met in a consistent manner across the organization.

The revised 2024 QIHETP is based on the 2024 QIHETP approved by the Board of Directors in April 2024 and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima Health's strategic initiatives.

The revisions are summarized as follows:

1. Updated QIHETP staffing and resources to reflect current organizational structure with a renamed Equity and Community Health Department (formerly known as the Population Health Management Department).
2. Updated sections in the QI Program to reflect current operational processes and workflows.

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3. Added the Cultural and Linguistic Appropriate Services Program to the QIHETP as Appendix D.
4. Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan.

The recommended changes to CalOptima Health's QIHETP reflect current clinical operations and are necessary to meet the requirements specified by the Centers for Medicare and Medicaid Services and the Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the revised 2024 QIHETP and Work Plan has no additional fiscal impact beyond what was incorporated in the proposed Fiscal Year 2024-25 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments

1. Revised 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Redline version)
2. Revised 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Clean version)
3. PowerPoint Presentation: 2024 Revised Quality Improvement and Health Equity Transformation Program and Work Plan

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: APRIL 1~~JANUARY 1~~, 2024 TO DECEMBER 31, 2024

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2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

________________________________ _________________

Richard Pitts, D.O., Ph.D. Date
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

________________________________ _________________

Trieu Tran, M.D. Date

Board of Directors Chairperson:

________________________________ _________________

Clayton M. Corwin Date

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
   a. Outcomes: Improve quality and health outcomes across the care journey.
   b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
   a. Advance health equity and whole-person care.
   b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
   a. Safety: Achieve zero preventable harm.
   b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
   a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.

b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.

Program Structure

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home.

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health has developed specialized care management (CM) services. These care management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with

certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A, B and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CCN). Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of nine HNs representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

CalOptima Health Community Network (CCN)

CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 9,000 specialists, 43 acute and rehabilitative hospitals, 52 community health centers and 106 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership

963,968

Program	Members
Medi-Cal	945,874
OneCare (HMO D-SNP)	17,648
Program of All -Inclusive Care for the Elderly (PACE)	446

***Based on unaudited financial report and includes prior period adjustment**

Membership Demographics (as of November 30, 2023)

Member Age

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

Language Preference

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

Medi-Cal Aid Category

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

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and

stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organizationwide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.

- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually.

The QIHETP is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (-four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

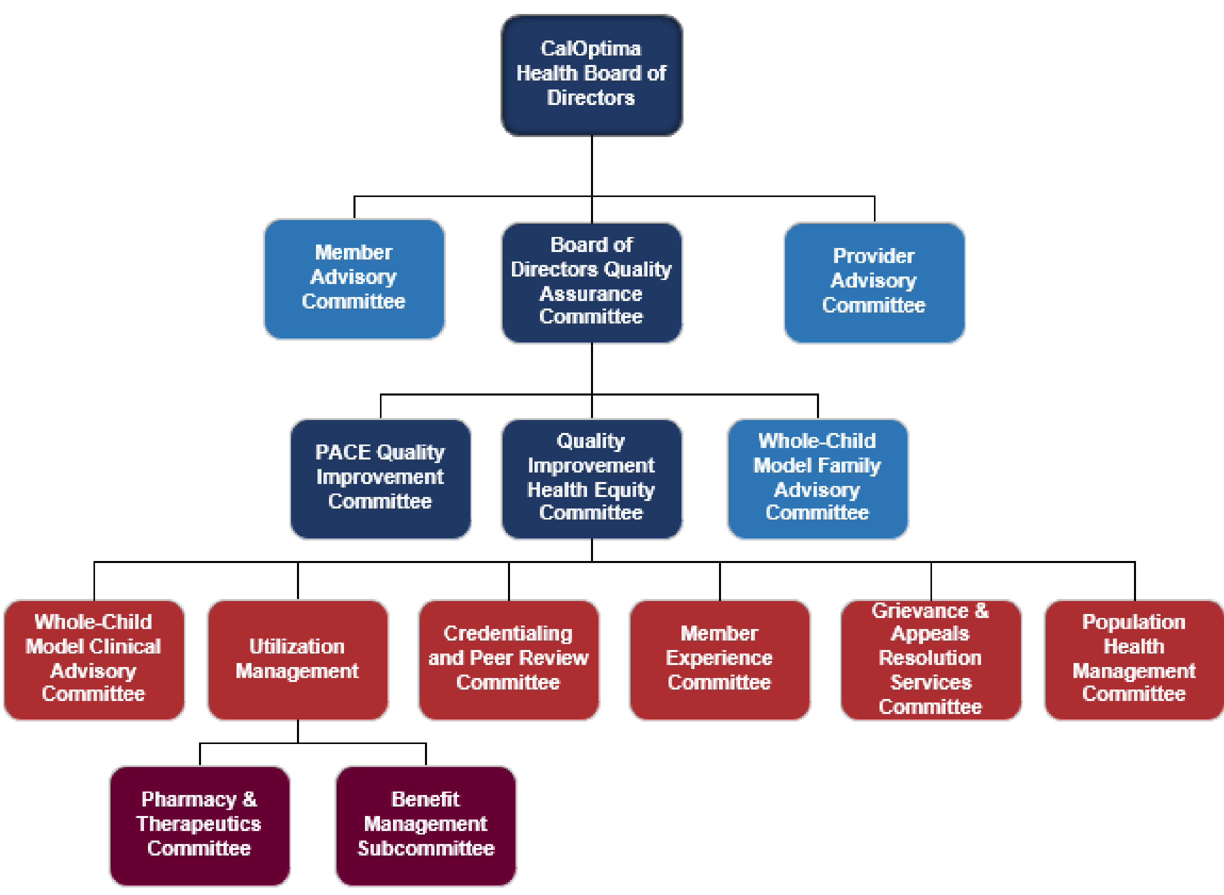
- Family representatives (nine seats)
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream

subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The QIHEC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QIHETP projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. Performance measurement and improvement activities and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

Responsibilities of the QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated HNs, including over/under utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIHEC is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, ~~Population Health Management~~Equity and Community Health
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIHEC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- ~~Population Health Management~~Equity and Community Health
- Quality Analytics
- Quality Improvement
- Utilization Management
- Director, Customer Service
- Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIHEC and all QIHE subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of HE proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIHEC provides to the QAC quarterly written progress reports of the QIHEC that describes actions taken, progress in meeting QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2024, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also

ensures that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima Health information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QIHE/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

2024 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health
   - Close racial/ethnic disparities in well-child visits and immunizations by 50%
   - Close maternity care disparity for Black and Native American persons by 50%
2. Children's Preventive Care
   - Exceed the 50th percentile for all children's preventive care measures
3. Behavioral Health Care
   - Improve maternal and adolescent depression screening by 50%
   - Improve follow-up for mental health and substance disorder by 50%
4. Program Goals
   - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
   - OneCare: Attain a Four-Star Rating for Medicare

Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service

- Member experience
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2024 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

For more details on the 2024 QIHETP Work Plan see Appendix A: 2024 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.

- Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
  - Health Network Forums – Monthly
  - HN Quality Forums – Quarterly
  - Joint Operation Meetings (JOM) with Health Networks – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used.

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size

may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIHEC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly in order to facilitate communication along the continuum of care. The QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

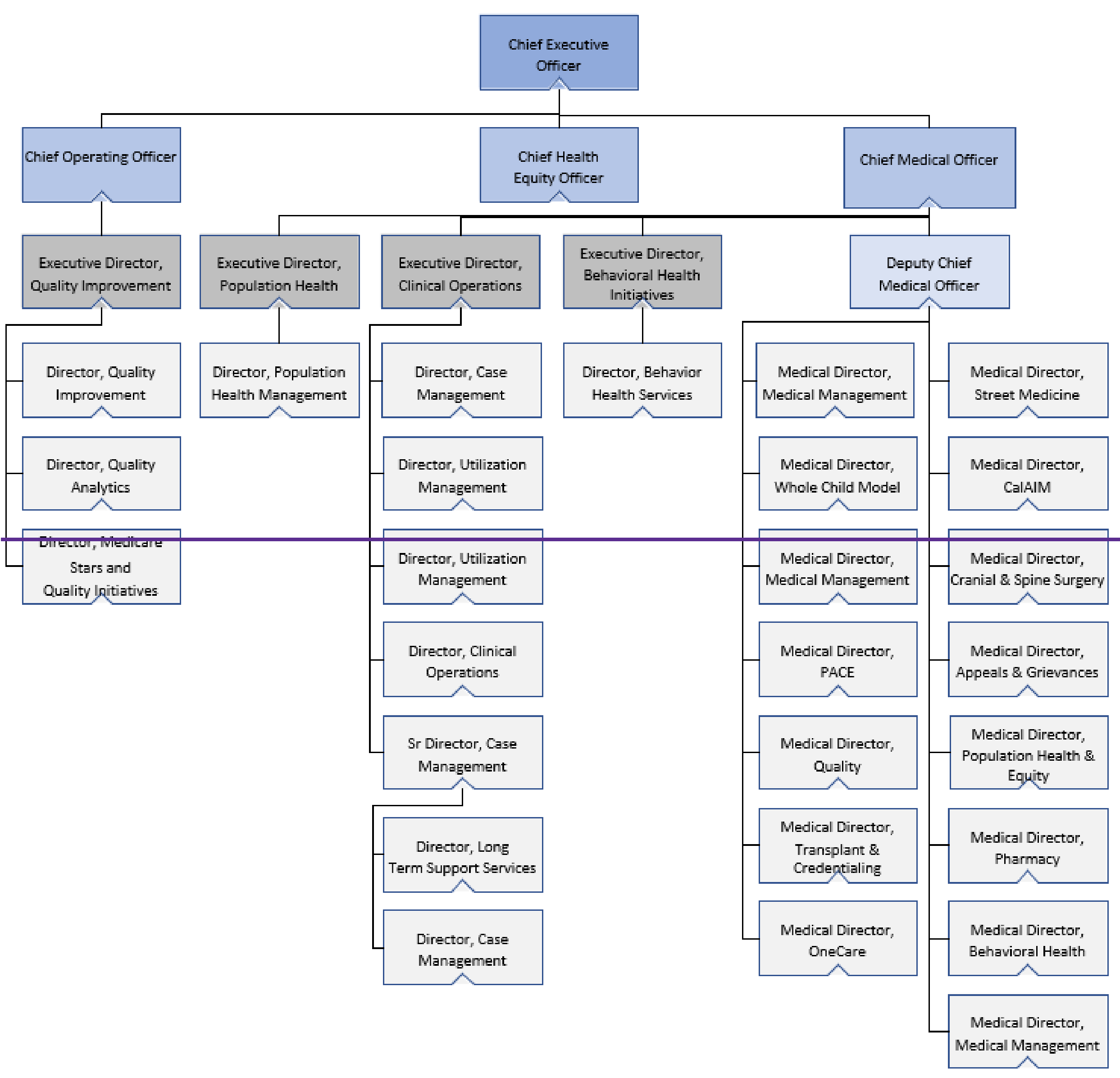
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

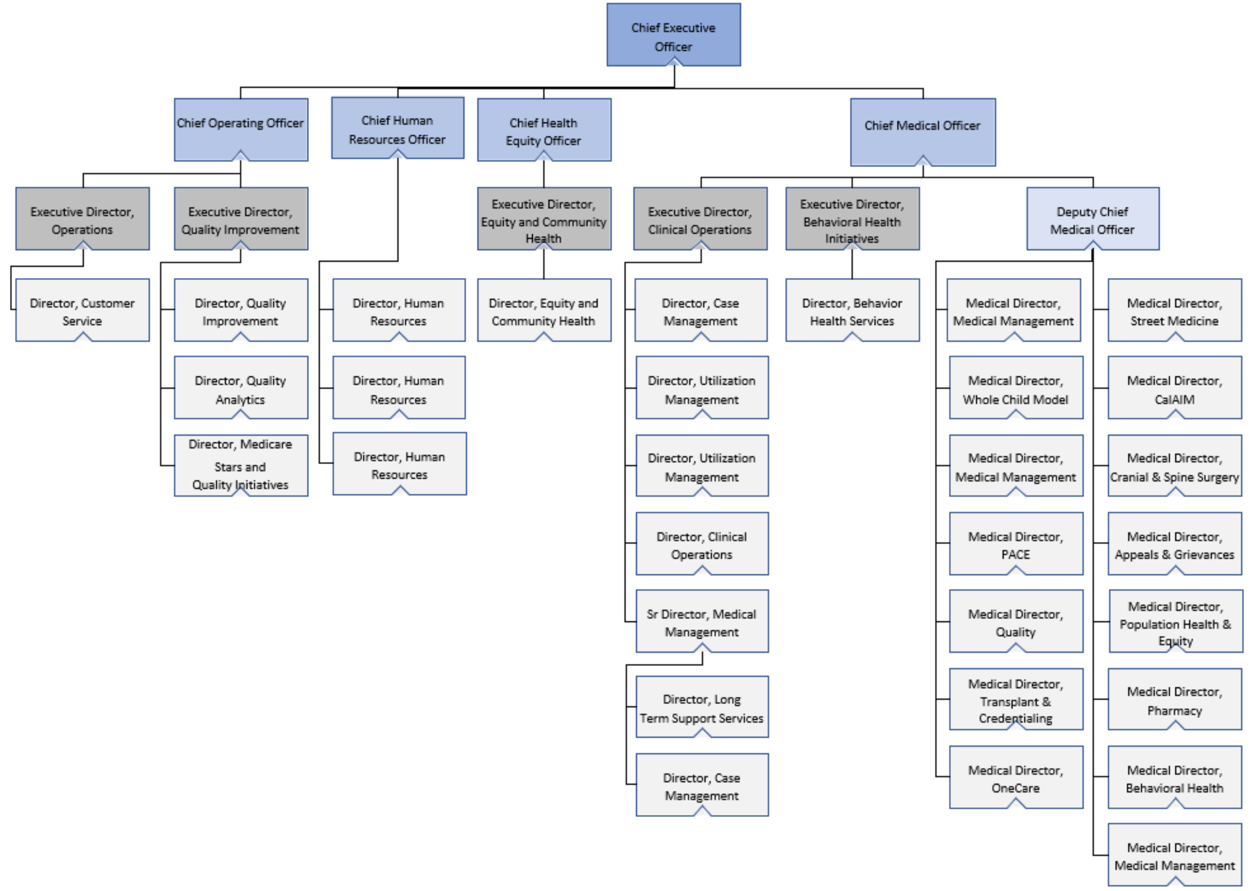
A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of ~~December 2023~~May 2024





Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are

coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, ~~Population Health Management,~~Equity and Community Health, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's ~~enterprisewide~~enterprise wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related

services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (~~Population Health and Equity~~Equity and Community Health) [ECH] is the designated physician who chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health ~~PHM~~ ECH staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, ~~Population Health Management~~Equity and Community Health (ED ECH~~PHM~~) is responsible for ~~the~~ oversight of ~~development and implementation of~~ comprehensive population ~~companywide PHM~~ strateg~~y~~ies to improve member experience ~~,~~ and increase access to care through the promotion of community-based programs~~promote optimal health outcomes, ensure efficient care and improve health equity~~. The ED ~~PHM~~ ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, ~~and~~

~~Executive Director, Clinical Operations,~~ supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity~~adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served~~. ~~The Director of Population Health Management~~Equity and Community Health ~~reports to the ED PHM~~ECH.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO, ED BHI and ED ECH ~~and ED PHM,~~ makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima Health’s CMO and , ED QI and ED PHMECHP, the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and

availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the ~~organizationwide~~organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:

- Manager, Quality Analytics
- Manager, Quality Initiatives
- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, ~~Population Health Management~~Equity and Community Health (ECH)
Responsible for program development and implementation of the PHM program and strategies for ~~organizationwide~~ comprehensive ~~population~~ health initiatives ~~while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI~~. This position oversees programs that promote health and wellness services for all CalOptima Health members. ~~PHM~~ ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.~~PHM ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.~~

~~In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs — focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members.~~

~~The following positions report to the Director, Population Health Management~~Equity and Community Health~~:~~

- ~~Equity and Community Health Managers:Population Health Management Manager (Clinical Operations)~~

- ~~Equity and Community Health:Population Health Management Manager (Health Education)~~
- ~~Equity and Community Health:Population Health Management Manager (Maternal Health)~~
- ~~Equity and Community Health:Population Health Management Manager (Strategic Initiatives)~~
- ~~Equity and Community Health:Population Health Management Supervisors~~
- ~~Program Managers and Senior Program Managers~~
- ~~Health Coaches~~
- ~~Registered Dietitians~~
- ~~Health Educators and Senior Health Educators~~
- ~~Program Specialists~~
- ~~Program Assistants~~
- ~~Program Coordinators~~

Director, Behavioral Health Integration
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)

Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Sr. Director, Medical Management
[Add Description]

Sr. Director, Clinical Operations
The Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct.

Director, Human Resources
-The Director (Human Resources Administrative Services) is responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs, and processes.

Director, Customer Service
Provide leadership, inResponsible for the day-to-day management, strategic direction and support to the CalOptima's Customer Services operations; Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic, Member Communications, Enrollment & Reconciliation, Member Advisory Committees and CalOptima Member Portal.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)

- HIPAA Rules and Compliance
- Disability Awareness Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive physical and behavioral health care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima Health model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care

- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:
- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and assuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
    - Drive improvement of quality of care received
    - Minimize rework and unnecessary costs
    - Measure the member experience of accessing and getting needed care
    - Empower staff to be more effective
    - Coordinate and communicate organizational information, both department-specific and organizationwide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organizationwide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner’s ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic

medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend

to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed triannual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and ~~PHM~~ ECH teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and

processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care

  Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs, including CCN, and HNs' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the PHM Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address SDOH and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by NCQA.

CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Plan.

The PHM Work Plan addresses the unique needs and challenges of specific ethnic communities, including social drivers of health that include but are not limited to economic, social and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives can be expected to have a beneficial effect on health outcomes and member satisfaction, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives are tracked in the QIHETP Work Plan and reported to the QIHEC.

In 2024, the PHM Work Plan will continue to focus on addressing health inequities and meeting member's social needs. ~~PHM~~ CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- ~~Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from the Equity in Orange County Initiative (EiOC).~~
- Expanding Street Medicine services to connect unhoused members with whole person care approaches and addressing social drivers of health.
- Expanding in-person group health education classes in the community to promote healthy eating and active living.
- Initiating interventions for members with hypertension and chronic kidney disease.
- Implementing the Comprehensive Community Cancer Screening and Support program that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs – focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission.

The primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate.

The ~~PHM~~ Equity and Community Health (ECH) department ~~provides program development and implementation for organizationwide PHM programs. PHM~~ programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members. The programs~~y~~ are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

~~The primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate.~~

~~PHM~~ ECH supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk ~~Members occurs~~Members occurs at the PCP level
    - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
        - Roles and responsibilities of this team:
            - Basic care management, including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of an Individual Care Plan (ICP)
            - Communication with members or their representatives, vendors and medical group
            - Review and update the ICP at least annually, and when there is a change in health status
            - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk ~~Members occurs~~Members occurs at the HN, or at CalOptima Health for CCN members.
    - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Care coordination or complex care management
            - Care management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating communication among member, PCP, specialists and vendors
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OneCare. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization

- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

CalOptima Health is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental

health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line.

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024 Integrated UM and CM Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for the plan and hence the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.

- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The seven most common languages spoken for all CalOptima Health programs are: English, 58%; Spanish, 27%; Vietnamese, 9%; Farsi, 1%; Korean, 2%; Chinese, less than 1%; and Arabic, less than 1%; and other less than 2%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Population Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical).

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Appropriate Services Program ~~and Work Plan~~.

DELEGATED AND NON-DELEGATED ACTIVITIES

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Care Management, Credentialing, Utilization Management, and Claims.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2024 QIHETP WORK PLAN

B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY

C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS

D – 2024 CULTURAL AND LINGUISTIC APPROPRIATE SERVICES PROGRAM

ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CLAS	Cultural and Linguistic Appropriate Service
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ECH	Equity and Community Health
	ED ~~PHM~~ECH	Executive Director, Equity and Community Health ~~Population Health Management~~
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health

	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs
	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long Term Care
	LTSS	Long Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity

	QIHEC	Quality Improvement and Health Equity Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

Submitted and approved by QIHEC: 05/14/2024
Quality Improvement Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. ______ Date ______

Submitted and approved by QAC: 06/12/2024
Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. ______ Date ______

I. PROGRAM OVERSIGHT

1 2024 Quality Improvement Annual Oversight of Program and Work Plan
2 2023 Quality Improvement Program Evaluation
3 2024 Integrated Utilization Management (UM) and Case Management (CM) Program Descriptior
4 2023 Integrated Utilization Management and Case Managemetn Program Evaluatior
5 Population Health Management Strategy
5.5 2024 Population Health Management (PHM) Strategy Evaluation
6 2024 Cultural and Linguistic Services Program and Work Plan
6.6 2024 Cultural and Linguistic Services Program Evaluation
7 Population Health Management (PHM) Committee
8 Credentialing Peer Review Committee (CPRC) Oversight
9 Grievance and Appeals Resolution Services (GARS) Committee
10 Member Experience (MEMX) Committee Oversight
11 Utilization Management Committee (UMC) Oversight
12 Whole Child Model - Clinical Advisory Committee (WCM CAC)
13 Care Management Program
14 Delegation Oversight
15 Disease Management Program
16 Health Education
17 Health Equity
18 Long-Term Support Services (LTSS)
19 National Committee for Quality Assurance (NCQA) Accreditation
20 OneCare STARs Measures Improvement
21 Value Based Payment Program
22 Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures
23 School-Based Services Mental Health Services
24 CalOptima Health Comprehensive Community Cancer Screening Program

II. QUALITY OF CLINICAL CARE- Adult Wellness

25 Preventive and Screening Services

III. QUALITY OF CLINICAL CARE- Behavioral Health

26 EPSDT Diagnostic and Treatment Services: [ADHD]
Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications [ADD]
27 Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare [ACES]
28 Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Metabolic Monitoring for Children and Adolescents on Antipsychotics [APM]
29 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care - [AMM]
30 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness [SMD]
31 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information [FUM]
32 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions [SSD]
33 Performance Improvement Projects (PIPs) Medi-Cal BH
34 Substance Use Disorder Services

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

35 Members with Chronic Conditions: Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
36 Members with Chronic Conditions: Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

V. QUALITY OF CLINICAL CARE- Maternal Child Health

37 Maternal and Child Health: Prenatal and Postpartum Care Services
37.5 Maternal and Adolescent Depression Screening

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

38 Blood Lead Screening
39 EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations
40 Item moved to section XIII. CLAS
41 Quality Improvement activities to meet MCAS Minimum Performance Level

VII. QUALITY OF CLINICAL CARE - QUALITY OVERSIGHT

42 Encounter Data Review
43 Facility Site Review (including Medical Record Review and Physical Accessibiltiy Review) Compliance
44 Potential Quality Issues Review
45 Initial Provider Credentialing

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46 Provider Re-Credentialing

VIII. QUALITY OF CLINICAL CARE
47 Chronic Improvement Projects (CCIPs) OneCare
48 Special Needs Plan (SNP) Model of Care (MOC)

IX. QUALITY OF SERVICE- Access
49 Improve Network Adequacy: Reducing gaps in provider network
50 Improve Access: Timely Access (Appointment Availability) / Telephone Access
51 Improving Access: Subcontracted Network Certification
52 Increase primary care utilization
~~53~~ Item moved to section XIII. CLAS
54 Improving Access: Annual Network Certification

X. QUALITY OF SERVICE- Member Experience
55 Improve Member Experience/CAHPS
56 Grievance and Appeals Resolution Services

XI. QUALITY OF SERVICE
57 Customer Service
57.5 Medi-Cal Customer Service Performance Improvement Project

XII. SAFETY OF CLINICAL CARE
~~58 Coordination of Care: Member movement across settings~~
59 Coordination of Care: Member movement between practitioners
60 Emergency Department Visits
61 Coordination of Care: Member movement across settings - Transitional Care Services (TCS)

XIII. Cultural and Linguistic Appropriate Services (CLAS)
~~40~~ 62 Performance Improvement Projects (PIPs) Medi-Cal
~~53~~ 63 Cultural and Linquistics and Language Accessibility
64 Maternity Care for Black and Native American Persons
65 Data Collection on Member Demographic Information
66 Data Collection on Pracitioner Demographic Information
67 Experience with Language Services

2024 QIHETP Work Plan Updated 4.1.24

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	~~QIHETP~~ Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	X			
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/XX/24 QAC: 12/XX/24 Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	**New**			
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Manager of Customer Service	~~TBD~~ Manager of Cultural and Linguistics	Cultural and Linguistic Services	X			
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/XX/24 QAC: 12/XX/24 Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	**New**			
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Director of Equity and Community Health	~~TBD~~ Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	**New**			
Program Oversight	**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of Grievance and Appeals	Manager of GARS	GARS	X			
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	X			
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Director of Utilization Management	Manager of UM	Utilization Management	X			
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	X			
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Director of Care Management	TBD	Medical Management	**New**			
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Director of Audit and Oversight	~~TBD~~ Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	**New**			
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Director of PHM	~~TBD~~ Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Director of Equity and Community Health/Manager of Health Education	TBD Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	x			
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	~~TBD~~ Manager of LTSS	Long Term Care	**New**			
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Program Manger of QI	Director of Quality Improvement	Quality Improvement	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	X			
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Manager of Quality Analytics	~~TBD~~ Manager Quality Analytics	Quality Analytics	X			
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Director of Quality Analytics	~~TBD~~ Manager Quality Analytics	Quality Analytics	X			
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	X			
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behaviroal Health Integration	Behavioral Health	**New**			
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behaviroal Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behaviroal Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare-Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare-Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	X			
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	X			
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramos	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	**New**			
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Director of Finance	Manager of Finance	Finance	**New**			
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibiltiy Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Next Steps Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - At Risk Yellow - Caution Green - On Target
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	1) Director of Provider Network 2) Director of Contracting	~~TBD~~ Analyst of Quality Analytics	Contracting	X			
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	~~TBD~~ Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	X			
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations/Quality Analytics	X			
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	~~TBD~~ Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Management Services	New			
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	X			
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of GARS	Manager of GARS	GARS	New			
Quality of Service	~~Medi-Cal~~ Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Director of Customer Service	~~TBD~~ Manager of Customer Service	Customer Service				
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Andrew Tse	Mike Erbe	Associate Director of Customer Services	Manager of Customer Service	Customer Service	New			
~~Safety of Clinical Care~~	~~Coordination of Care: Member movement across settings~~	~~Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting~~	~~Assess and report the following activities:~~ ~~1) Collaborative meetings between teams to identify best practices to implement~~ ~~2) Provider and member education~~	~~UMC Committee report to QIHEC:~~ ~~Q2: 06/11/2024~~ ~~Q3: 09/10/2024~~ ~~Q4: 12/10/2024~~ ~~Q1 03/11/2025~~	~~Stacie Oakley~~	~~TBD~~	~~Director of Utilization Management~~	~~TBD~~	~~Utilization Management~~	~~New~~			
Safety of Clinical Care	Coordination of Care: Member movement across ~~settings~~ pracittioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Director of Case Management	TBD	Medical Management	New			
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	LTSS	X			
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Director of UM, CM and LTSS	~~TBD~~ Manager of Medical Management	Utilization Management Case Management Long Term Care	X			
~~Quality of Clincial Care~~ Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	~~Meet and exceed goals set forth on all improvement projects~~ Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024..	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
~~Quality of Clincial Care~~ Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Cultural and Linguistic Services				
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	~~Meet the following goals For MY2024 HEDIS:~~ ~~PPC Postpartum: Black 74.74%; Native American 63.22%~~ ~~PPC Prenatal: Black 72.37%; Native American 59.43%~~ 1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	New			
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey to distribute during the monthly New member orientation sessions. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	New			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	**New**			
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and lingustic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

2024

POPULATION HEALTH MANAGEMENT STRATEGY & WORK PLAN

Responsible Staff:

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INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

Our Mission

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

Our Vision

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

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

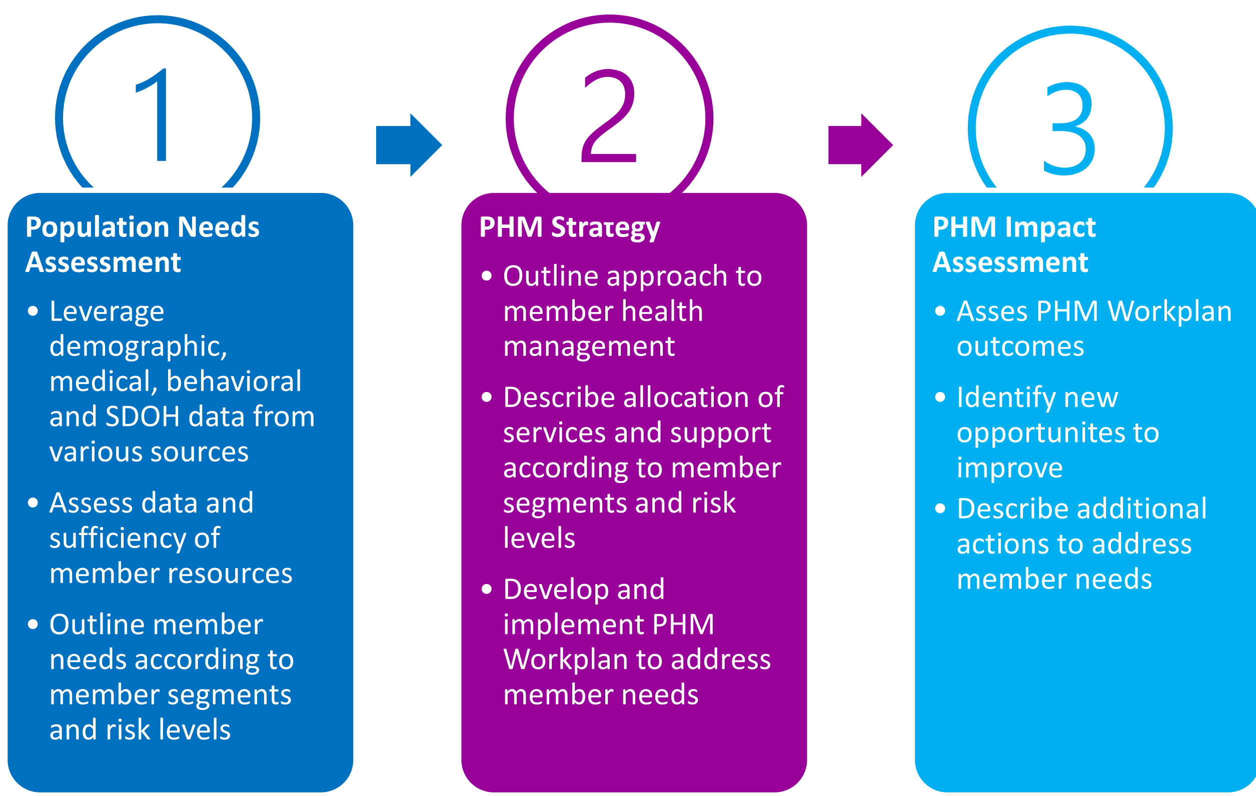
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

STRATEGIC MANAGEMENT

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.

Highest Risk

Enhanced Care Management (ECM) is for the highest-need CalOptima Health members and provides intensive coordination of health and health-related services.

Medium - High Risk

Complex Care Management (CCM) is for CalOptima Health members at higher and medium-rising risk and provides ongoing chronic care coordination, interventions for temporary needs and disease-specific management interventions.

No - Low Risk

Basic Population Health Management is an array of services for **all** CalOptima Health members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.

Gathering Member Information
- Initial Screening
  - HIF/MET
- Claims/Encounters /Other Data

Understanding Risk
- Risk Stratification and Segmentation
- Risk Tiering
- Assessment & Reassessment for Care Management

Providing Services and Supports
- Basic Population Health Management
  - Everyone in the Medi-Cal population
- Care Management
  - ECM
  - Complex Care Coordination
  - Disease Management /Health Education
- Transitional Care Services (as needed)

PHM Strategy and Population Needs Assessment (PNA)

PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments and health care. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

Activities and Resources

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

Delivery System Supports

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions. Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care Coordinators, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

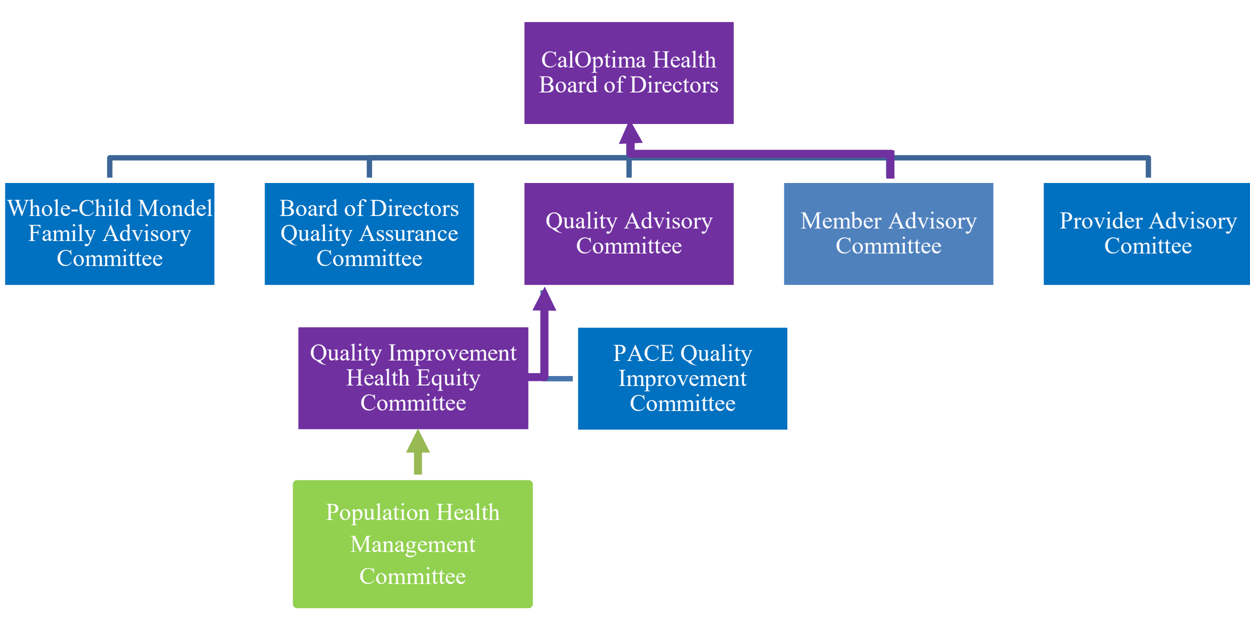
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024 Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

- Utilize both Child and Adult CAHPS scores.
  - To calculate performance, average scores

2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2024 Culturally and Linguistically Appropriate Services (CLAS) Program Description

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal**– California's Medicaid Program for low-income children, adults, seniors, and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO-DSNP)** – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

Membership Demographics

Membership Data* (as of March 31, 2024)

Total CalOptima Health Membership

932,168

Program	Members
Medi-Cal	914,417
OneCare (HMO D-SNP)	17,277
Program of All-Inclusive Care for the Elderly (PACE)	474

*Based on unaudited financial report and includes prior period adjustment

Member Demographics (as of March 31, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation.

Objectives for service a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program.

Board of Directors' Quality Assurance Committee

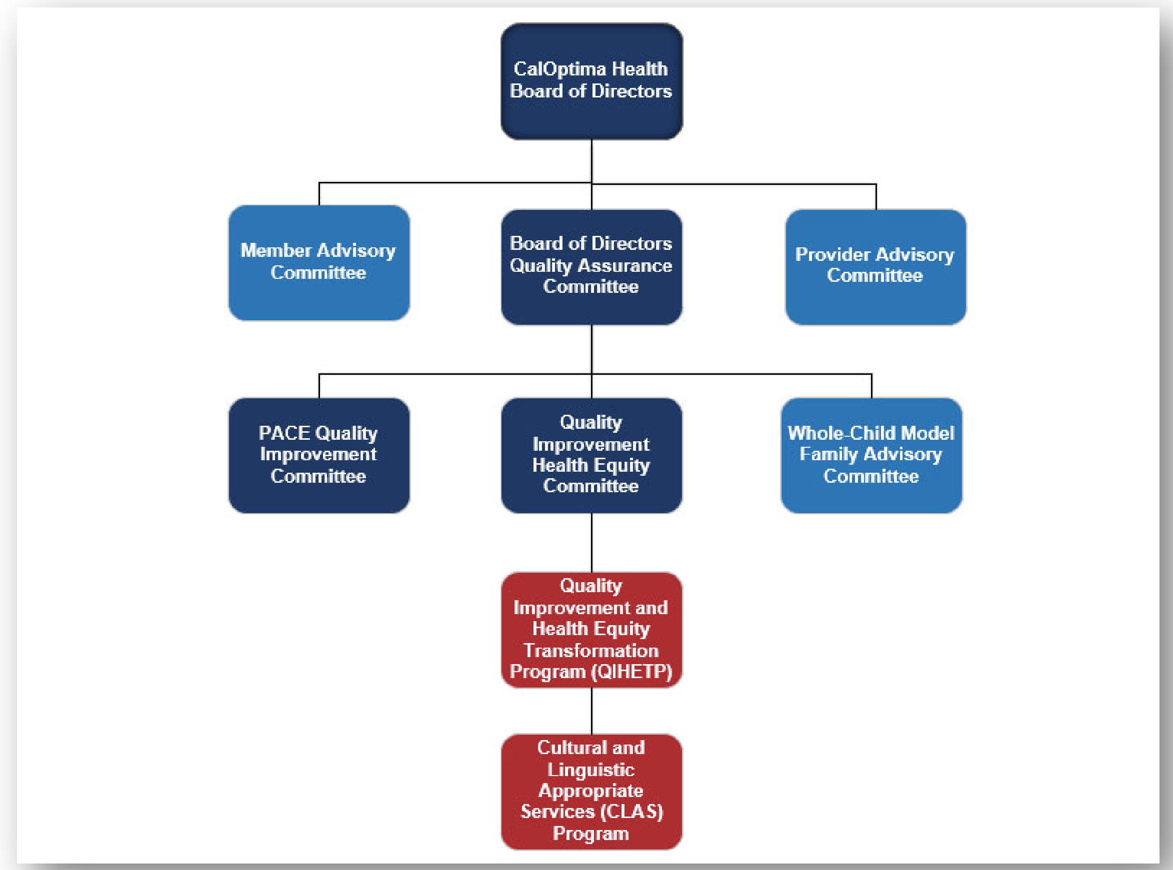
The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI, Health Equity and CLAS contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program, and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated, and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

CLAS Reporting Structure



Community and Member Engagement

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals. The MAC has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services in order to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

MAC represents the diversity of its membership. The following table depicts the current MAC break down by ethnic diversity. MAC includes individuals representing the ethnicity and language groups that represent at least 5% of the population. Please note that as of April 1, 2024, one Family Support Representative and two OneCare member seats remain unfilled and are currently under recruitment.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	46%	Spanish	31%	5	4 OneCare Members 1 Behavioral/Mental Health Representative
White	17%	English	55%	8	1 Adult Beneficiaries 1 Children 1 Foster Children 2 Medi-Cal Beneficiaries or Authorized Family Members 1 Persons with Special Needs 1 Recipients of CalWORKs 1 Seniors
Vietnamese	13%	Vietnamese	9%	1	1 Persons with Disabilities
Korean	3%	Korean	1%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups or meetings and survey, such as implementing a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientation Meetings.

Goals

The following are the goals of the CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate language services experience from members and staff.
3. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
4. Improve practitioner support in providing language services.

CLAS Work Plan

The CLAS Work Plan is a subset of and is imbedded within the QIHETP Work Plan and outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope

- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the CLAS Program and applicable policies and procedures. The 2024 CLAS Work Plan includes all cultural and linguistic focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve collection, storing, retrieval and sharing of race/ethnicity, language, sexual orientation and gender identity data. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans are also publicly available on the CalOptima Health website.

For more details on the 2024 CLAS Work Plan see Appendix A: 2024 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health continuously monitors progress against CLAS goals. At least quarterly, dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes, and outputs. C&L staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at Quality Improvement Health Equity Committee (QIHEC) meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Director's Quality Assurance Committee (QAC).

CLAS Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's CLAS Program are reviewed and evaluated annually by the QIHEC and QAC, as part of the overall CLAS Program Evaluation and approved by the Board of Directors, as reflected in the CLAS Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the CLAS Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

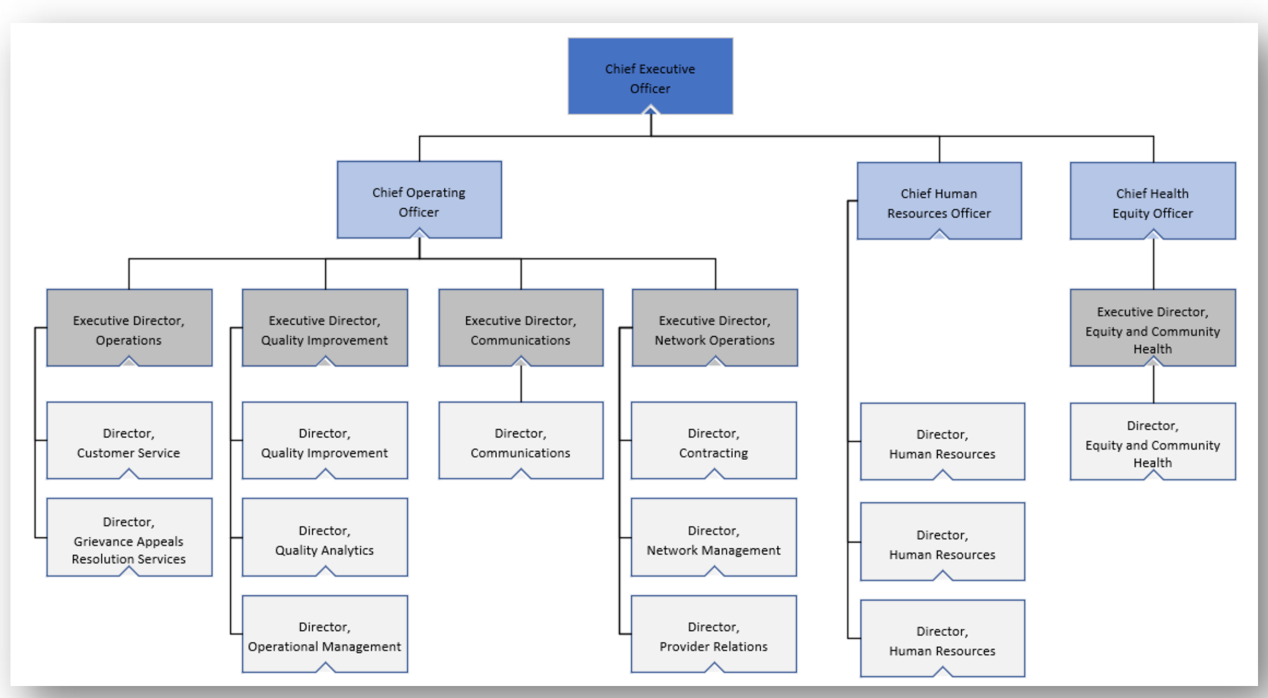
- A description of completed and ongoing CLAS activities that address cultural and linguistic needs or our members, including the achievement or progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of

translation and interpreter services.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs, and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the CLAS Evaluation is also publicly available on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, Manager of Cultural and Linguistics, and nine Program Specialists who are responsible for translation of documents and coordinating cultural and linguistic services with contracted vendors. The Cultural and Linguistics department is supported by CalOptima Health departments including but not limited to:
- Communications
- Contracting
- Customer Service
- Equity and Community Health
- Human Resources
- Network Management
- Provider Relations
- Quality Analytics

Cultural and Linguistic Service Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health’s mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts; responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, and CalOptima Member Portal.

Director, Grievance Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including to ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Operational Management is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. Interact with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiate provider contracts.

Director, Network Management is responsible for all operational aspects of the Network Management department. The incumbent will oversee the onboarding of all new provider partners, provider data management and analysis and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards; leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of healthcare services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources (Administrative Services) is responsible for leading and overseeing the Human Resources services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer..

Director, Equity and Community Health (ECH) is responsible for program development and implementation for comprehensive population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.

Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services

Language Services

CalOptima Health's Culturally and Linguistically Appropriate Services (CLAS) ensures all members have access to health care related interpreter services in any language and translated member materials in CalOptima's threshold languages.

Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information are available in English, Spanish, Vietnamese, Arabic, Farsi, Korean, and Chinese.
- Provide oral translation for other languages upon request or as needed, by a qualified translator at no cost.

- Provide routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay, or modification of benefits, and the right to file a Grievance or Appeal at no cost.
- Free access to materials in alternative format such as Braille, large print, data, and audio files.
- Free access to 24 hours access to telephonic interpreter services to members with limited English proficiency at no cost.
- Free Remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of-hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

- "Language Interpreting Services" poster in the reception area where members can point to their preferred language
- Member handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New member orientations
- Customer Service Call Center
- Health education workshops
- C&L "We Speak Your Language" brochure
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations (CBOs) and public agencies

CalOptima Health provides informational materials to members written at a no higher than a sixth (6th) grade reading level and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

- Eligible beneficiaries residing in the CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness with:

- Race: any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape;
- Ethnicity: a group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- Culture: the ideas, customs, skills, arts, etc. of a people or group, that are transferred, communicated, or passed along, as in or to succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation, and gender identity.

During onboarding of new employees, on an annual basis, and as needed, CalOptima health ensures CalOptima health staff, Providers, Health Networks, and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Trainings include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new Employee "Boot Camp" C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

Promotion of Diversity

CalOptima Health is committed to reducing bias and improving diversity, equity and inclusion and supports initiatives to recruit, retain and train a diverse healthcare workforce that reflects the cultural and linguistic diversity of the communities serviced. This includes the following:

- Inclusive job descriptions and hiring practices.
- Trainings on the following topics for leaders:
    - Diversity, Inclusion & Conscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Conduct regular pay equity analysis
- Offer benefits and perks to support the diverse needs of employees (ie. Flexible work

arrangements)

Data Collect and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Focused is placed on collecting, storing and retrieving member health care data in order to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identify and sexual orientation.
- Health outcomes
- Language preferences

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance and health care data are stratified by race, ethnicity, language, and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan where progress of planned activities is tracked towards achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: APRIL 1, 2024 TO DECEMBER 31, 2024

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

________________________________ __________________

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

________________________________ __________________

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

________________________________ __________________

Clayton M. Corwin **Date**

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.

b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.

Program Structure

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home.

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health has developed specialized care management (CM) services. These care management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with

certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A, B and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CCN). Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of nine HNs representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

CalOptima Health Community Network (CCN)

CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 9,000 specialists, 43 acute and rehabilitative hospitals, 52 community health centers and 106 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership

963,968

Program	Members
Medi-Cal	945,874
OneCare (HMO D-SNP)	17,648
Program of All -Inclusive Care for the Elderly (PACE)	446

***Based on unaudited financial report and includes prior period adjustment**

Membership Demographics (as of November 30, 2023)

Member Age

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

Language Preference

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

Medi-Cal Aid Category

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

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and

stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.
- Maintain organizationwide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.
- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.
- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.
- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually.

The QIHETP is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

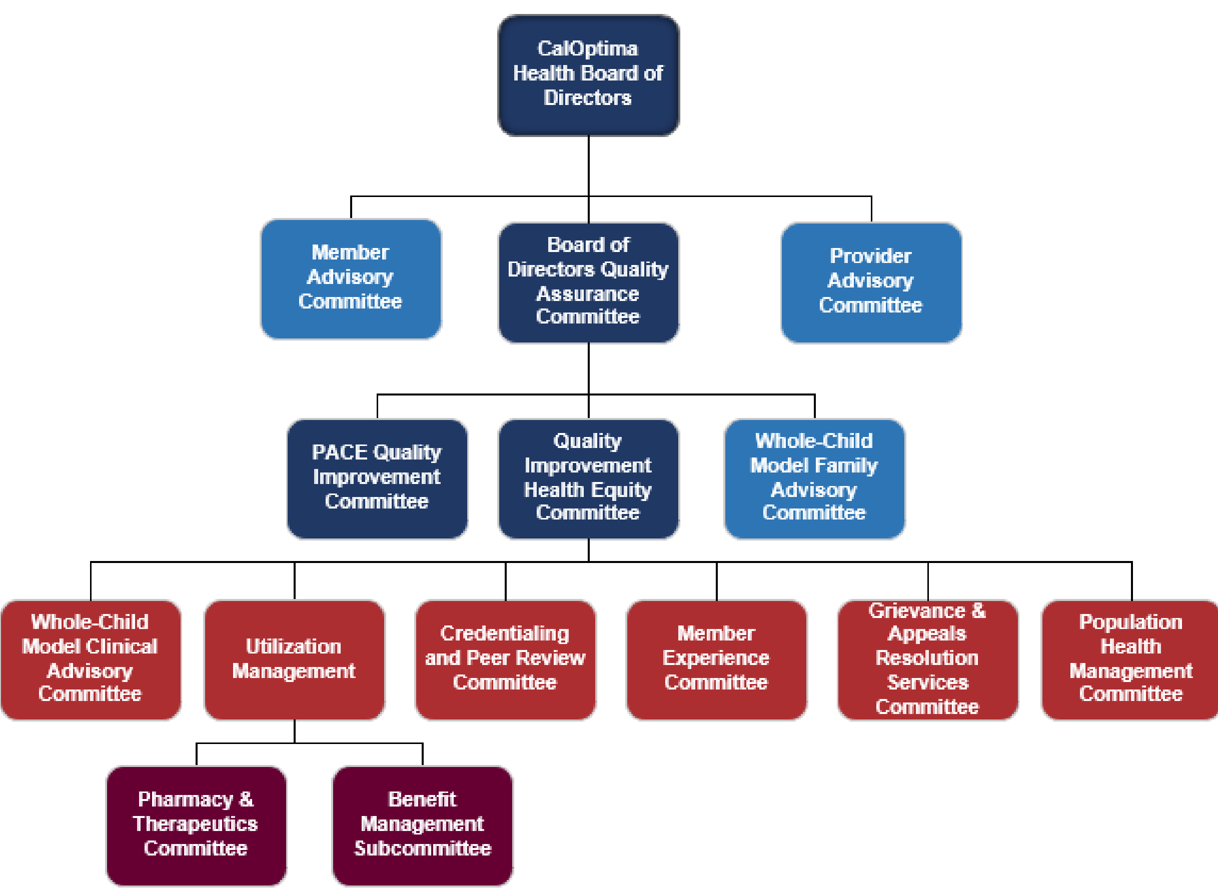
- Family representatives (nine seats)
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream

subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The QIHEC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QIHETP projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. Performance measurement and improvement activities and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

Responsibilities of the QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated HNs, including over/under utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIHEC is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, Equity and Community Health
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIHEC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- Equity and Community Health
- Quality Analytics
- Quality Improvement
- Utilization Management
- Director, Customer Service
- Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIHEC and all QIHE subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of HE proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIHEC provides to the QAC quarterly written progress reports of the QIHEC that describes actions taken, progress in meeting QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the

UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2024, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also ensures that all population health initiatives are performed, monitored and communicated

according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima Health information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QIHE/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

2024 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health
   - Close racial/ethnic disparities in well-child visits and immunizations by 50%
   - Close maternity care disparity for Black and Native American persons by 50%
2. Children's Preventive Care
   - Exceed the 50th percentile for all children's preventive care measures
3. Behavioral Health Care
   - Improve maternal and adolescent depression screening by 50%
   - Improve follow-up for mental health and substance disorder by 50%
4. Program Goals
   - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
   - OneCare: Attain a Four-Star Rating for Medicare

Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service

- Member experience
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2024 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

For more details on the 2024 QIHETP Work Plan see Appendix A: 2024 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.

- Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
    - Health Network Forums – Monthly
    - HN Quality Forums – Quarterly
    - Joint Operation Meetings (JOM) with Health Networks – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used.

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size

may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIHEC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly in order to facilitate communication along the continuum of care. The QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

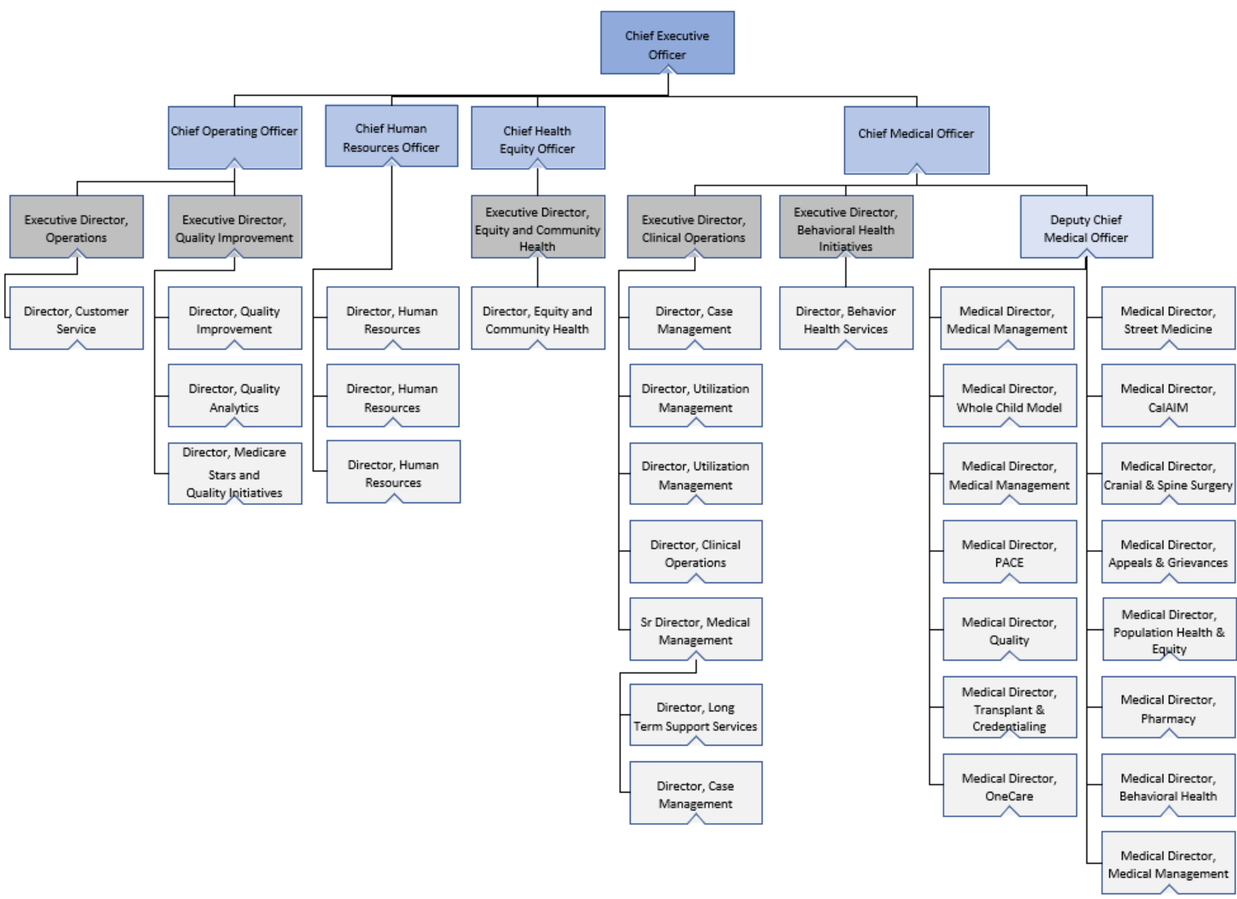
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of May 2024



Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Equity and Community Health, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

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Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (Equity and Community Health) [ECH] is the designated physician who chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health ECH staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity..

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO, ED BHI and ED ECH makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima Health's CMO and ED QI the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality

measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:
- Manager, Quality Analytics
- Manager, Quality Initiatives
- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, Equity and Community Health (ECH)
Responsible for program development and implementation of the PHM program and strategies for comprehensive health initiatives. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Integration
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-

related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Sr. Director, Clinical Operations
The Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct.

Director, Human Resources
The Director (Human Resources Administrative Services) is responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs, and processes.

Director, Customer Service
Responsible for the day-to-day management, strategic direction and support to the CalOptima's Customer Services operations; Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic, Member Communications, Enrollment & Reconciliation, Member Advisory Committees and CalOptima Member Portal.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Disability Awareness Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive physical and behavioral health care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima Health model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and assuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and organizationwide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organizationwide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member.

Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of

preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed triannual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima

Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and ECH teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care
  Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys

- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs, including CCN, and HNs' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the PHM Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima

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Health also shares our creative upstream approach to address SDOH and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by NCQA.

CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Plan.

The PHM Work Plan addresses the unique needs and challenges of specific ethnic communities, including social drivers of health that include but are not limited to economic, social and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives can be expected to have a beneficial effect on health outcomes and member satisfaction, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives are tracked in the QIHETP Work Plan and reported to the QIHEC.

In 2024, the PHM Work Plan will continue to focus on addressing health inequities and meeting member's social needs. CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- Expanding Street Medicine services to connect unhoused members with whole person care approaches and addressing social drivers of health.
- Expanding in-person group health education classes in the community to promote healthy eating and active living.
- Initiating interventions for members with hypertension and chronic kidney disease.
- Implementing the Comprehensive Community Cancer Screening and Support program that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs – focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission.

The primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate.

The Equity and Community Health (ECH) department programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members. The programs are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

ECH supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk Members occurs at the PCP level
    - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
        - Roles and responsibilities of this team:
            - Basic care management, including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of an Individual Care Plan (ICP)
            - Communication with members or their representatives, vendors and medical group
            - Review and update the ICP at least annually, and when there is a change in health status
            - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members occurs at the HN, or at CalOptima Health for CCN members.
    - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Care coordination or complex care management
            - Care management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating communication among member, PCP, specialists and vendors
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an

established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OneCare. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services

- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

CalOptima Health is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include but are not limited to individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line.

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024 Integrated UM and CM Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys

for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for the plan and hence the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The seven most common languages spoken for all CalOptima Health programs are: English, 58%; Spanish, 27%; Vietnamese, 9%; Farsi, 1%; Korean, 2%; Chinese, less than 1%; and Arabic, less than 1%; and other less than 2%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Population Needs Assessment,

programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical).

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Appropriate Services Program.

Delegated And Non-Delegated Activities

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Care Management, Credentialing, Utilization Management, and Claims.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2024 QIHETP WORK PLAN

B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY

C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS

D – 2024 CULTURAL AND LINGUISTIC APPROPRIATE SERVICES PROGRAM

ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CLAS	Cultural and Linguistic Appropriate Service
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ECH	Equity and Community Health
	ED ECH	Executive Director, Equity and Community Health
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations

	ED MP	Executive Director, Medicare Programs
	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long Term Care
	LTSS	Long Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity
	QIHEC	Quality Improvement and Health Equity Committee

	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

I. PROGRAM OVERSIGHT

1 2024 Quality Improvement Annual Oversight of Program and Work Plan
2 2023 Quality Improvement Program Evaluation
3 2024 Integrated Utilization Management (UM) and Case Management (CM) Program Descriptior
4 2023 Integrated Utilization Management and Case Managemetn Program Evaluatior
5 Population Health Management Strategy
5.5 2024 Population Health Management (PHM) Strategy Evaluation
6 2024 Cultural and Linguistic Services Program and Work Plan
6.6 2024 Cultural and Linguistic Services Program Evaluation
7 Population Health Management (PHM) Committee
8 Credentialing Peer Review Committee (CPRC) Oversight
9 Grievance and Appeals Resolution Services (GARS) Committee
10 Member Experience (MEMX) Committee Oversight
11 Utilization Management Committee (UMC) Oversight
12 Whole Child Model - Clinical Advisory Committee (WCM CAC)
13 Care Management Program
14 Delegation Oversight
15 Disease Management Program
16 Health Education
17 Health Equity
18 Long-Term Support Services (LTSS)
19 National Committee for Quality Assurance (NCQA) Accreditation
20 OneCare STARs Measures Improvement
21 Value Based Payment Program
22 Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures
23 School-Based Services Mental Health Services
24 CalOptima Health Comprehensive Community Cancer Screening Program

II. QUALITY OF CLINICAL CARE- Adult Wellness

25 Preventive and Screening Services

III. QUALITY OF CLINICAL CARE- Behavioral Health

26 EPSDT Diagnostic and Treatment Services: [ADHD]
Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications [ADD]
27 Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare [ACES]
28 Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Metabolic Monitoring for Children and Adolescents on Antipsychotics [APM]
29 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care - [AMM]
30 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness [SMD]
31 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information [FUM]
32 Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions [SSD]
33 Performance Improvement Projects (PIPs) Medi-Cal BH
34 Substance Use Disorder Services

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

35 Members with Chronic Conditions: Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
36 Members with Chronic Conditions: Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

V. QUALITY OF CLINICAL CARE- Maternal Child Health

37 Maternal and Child Health: Prenatal and Postpartum Care Services
37.5 Maternal and Adolescent Depression Screening

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

38 Blood Lead Screening
39 EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations
40 Item moved to section XIII. CLAS
41 Quality Improvement activities to meet MCAS Minimum Performance Level

VII. QUALITY OF CLINICAL CARE - QUALITY OVERSIGHT

42 Encounter Data Review
43 Facility Site Review (including Medical Record Review and Physical Accessibiltiy Review) Compliance
44 Potential Quality Issues Review
45 Initial Provider Credentialing

Submitted and approved by QIHEC: 05/14/2024
Quality Improvement Health Equity Committee Chairperson:

______________________ ______________
Richard Pitts, D.O., Ph.D. Date

Submitted and approved by QAC: 06/12/2024
Board of Directors' Quality Assurance Committee Chairperson:

______________________ ______________
Trieu Thanh Tran, M.D. Date

46 Provider Re-Credentialing

VIII. QUALITY OF CLINICAL CARE
47 Chronic Improvement Projects (CCIPs) OneCare
48 Special Needs Plan (SNP) Model of Care (MOC)

IX. QUALITY OF SERVICE- Access
49 Improve Network Adequacy: Reducing gaps in provider network
50 Improve Access: Timely Access (Appointment Availability) / Telephone Access
51 Improving Access: Subcontracted Network Certification
52 Increase primary care utilization
~~53~~ Item moved to section XIII. CLAS
54 Improving Access: Annual Network Certification

X. QUALITY OF SERVICE- Member Experience
55 Improve Member Experience/CAHPS
56 Grievance and Appeals Resolution Services

XI. QUALITY OF SERVICE
57 Customer Service
57.5 Medi-Cal Customer Service Performance Improvement Project

XII. SAFETY OF CLINICAL CARE
~~58 Coordination of Care: Member movement across settings~~
59 Coordination of Care: Member movement between practitioners
60 Emergency Department Visits
61 Coordination of Care: Member movement across settings - Transitional Care Services (TCS)

XIII. Cultural and Linguistic Appropriate Services (CLAS)
62 Performance Improvement Projects (PIPs) Medi-Cal
63 Cultural and Linquistics and Language Accessibility
64 Maternity Care for Black and Native American Persons
65 Data Collection on Member Demographic Information
66 Data Collection on Pracitioner Demographic Information
67 Experience with Language Services

2024 QIHETP Work Plan Updated 4.1.24

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	X			
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	**New**			
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X			
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	**New**			
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	**New**			
Program Oversight	**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of Grievance and Appeals	Manager of GARS	GARS	X			
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	X			
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Director of Utilization Management	Manager of UM	Utilization Management	X			
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	X			
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Director of Care Management	TBD	Medical Management	**New**			
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	**New**			
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Director of PHM	Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	x			
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	Long Term Care	**New**			
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Program Manger of QI	Director of Quality Improvement	Quality Improvement	X			

2024 QIHETP Work Plan Updated 4.1.24

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	X			
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	X			
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	X			
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	X			
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	Program Specialist of Behaviroal Health Integration	Behavioral Health	**New**			
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	Program Specialist of Behaviroal Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	X			
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	X			
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramos	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	**New**			
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Director of Finance	Manager of Finance	Finance	**New**			
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibiltiy Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	1) Director of Provider Network 2) Director of Contracting	Analyst of Quality Analytics	Contracting	X			
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	X			
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations/Quality Analytics	X			
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Management Services	**New**			
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	X			
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of GARS	Manager of GARS	GARS	**New**			
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Director of Customer Service	Manager of Customer Service	Customer Service				
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Andrew Tse	Mike Erbe	Associate Director of Customer Services	Manager of Customer Service	Customer Service	**New**			
Safety of Clinical Care	Coordination of Care: Member movement across pracittioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Director of Case Management	TBD	Medical Management	**New**			
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	LTSS	X			
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Director of UM, CM and LTSS	Manager of Medical Management	Utilization Management Case Management Long Term Care	X			
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024..	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Cultural and Linguistic Services				
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	**New**			
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey to distribute during the monthly New member orientation sessions. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	**New**			
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and lingustic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

2024
Population Health Management Strategy & Work plan

Responsible Staff:

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INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

Our Mission

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

Our Vision

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

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

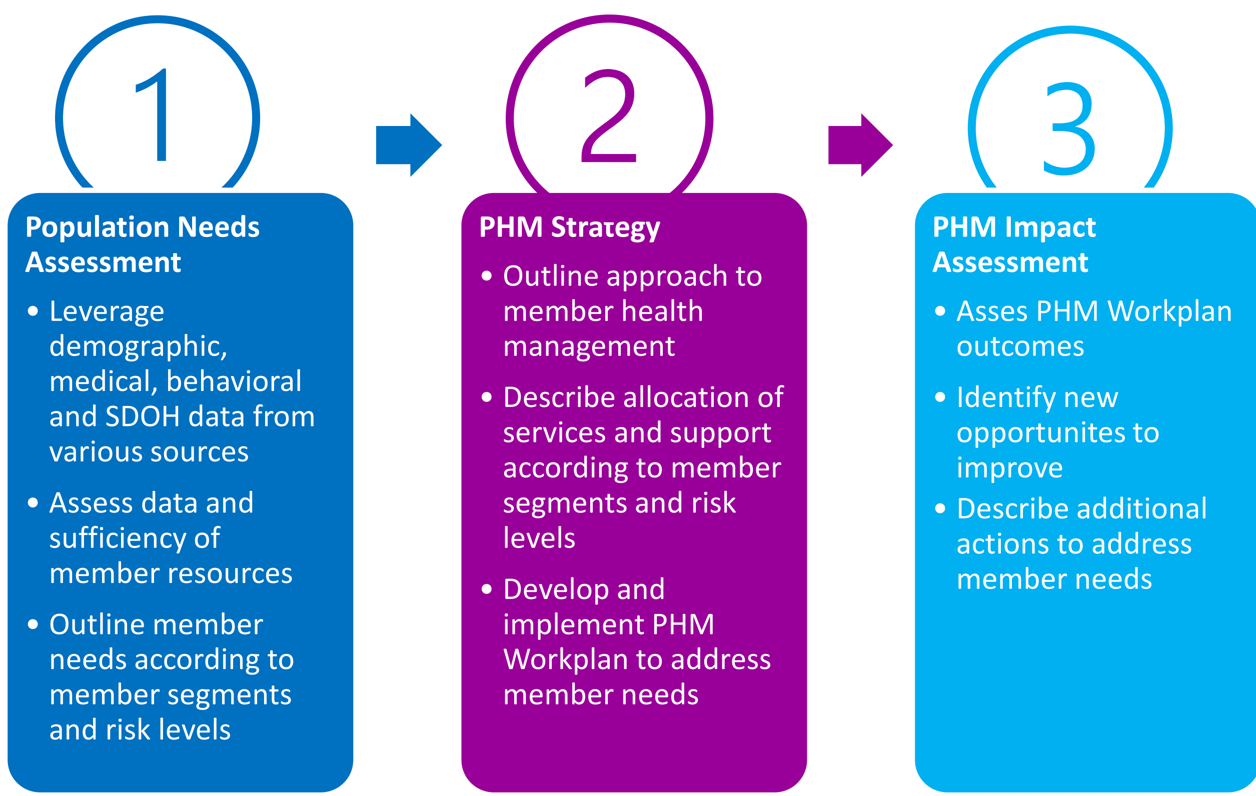
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.

Highest Risk

Enhanced Care Management (ECM) is for the highest-need CalOptima Health members and provides intensive coordination of health and health-related services.

Medium - High Risk

Complex Care Management (CCM) is for CalOptima Health members at higher and medium-rising risk and provides ongoing chronic care coordination, interventions for temporary needs and disease-specific management interventions.

No - Low Risk

Basic Population Health Management is an array of services for **all** CalOptima Health members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.

Gathering Member Information
- Initial Screening
  - HIF/MET
- Claims/Encounters /Other Data

Understanding Risk
- Risk Stratification and Segmentation
- Risk Tiering
- Assessment & Reassessment for Care Management

Providing Services and Supports
- Basic Population Health Management
  - Everyone in the Medi-Cal population
- Care Management
  - ECM
  - Complex Care Coordination
  - Disease Management /Health Education
- Transitional Care Services (as needed)

PHM Strategy and Population Needs Assessment (PNA)

PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

Promoting Health Equity

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments and health care. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

Delivery System Supports

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM STRUCTURE

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions.
  Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care Coordinators, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

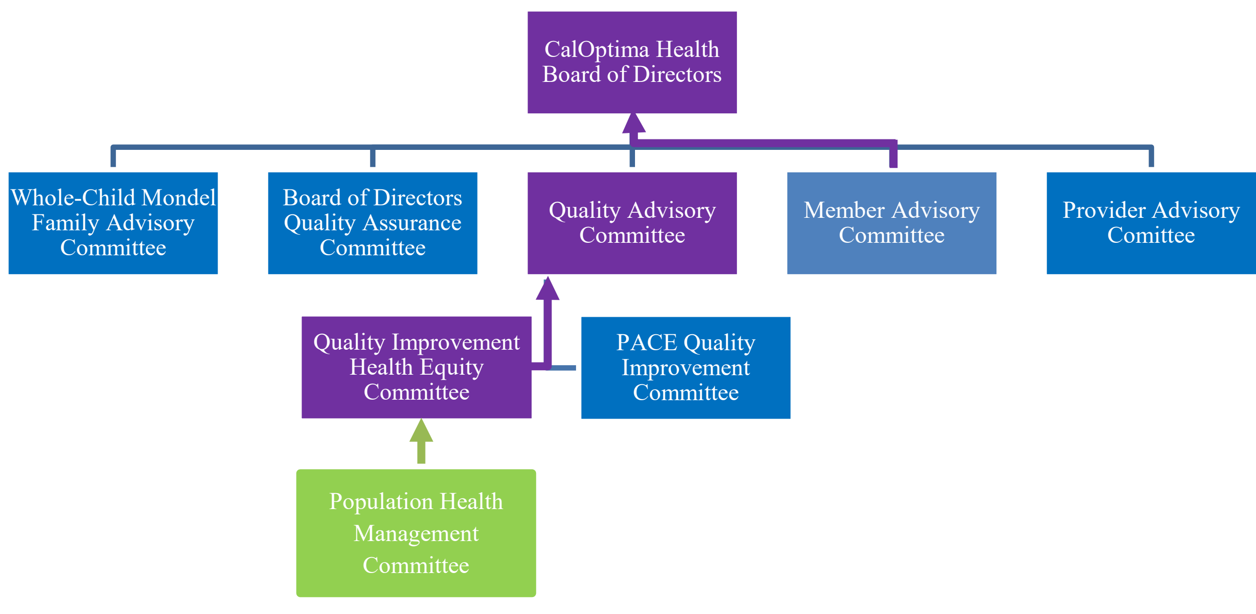
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

- Utilize both Child and Adult CAHPS scores.
  - To calculate performance, average scores

2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2024 Culturally and Linguistically Appropriate Services (CLAS) Program Description

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal**– California's Medicaid Program for low-income children, adults, seniors, and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO-DSNP)** – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

Membership Demographics

Membership Data* (as of March 31, 2024)

Total CalOptima Health Membership	Program	Members
932,168	Medi-Cal	914,417
	OneCare (HMO D-SNP)	17,277
	Program of All-Inclusive Care for the Elderly (PACE)	474

*Based on unaudited financial report and includes prior period adjustment

Member Demographics (as of March 31, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation.

Objectives for service a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program.

Board of Directors' Quality Assurance Committee

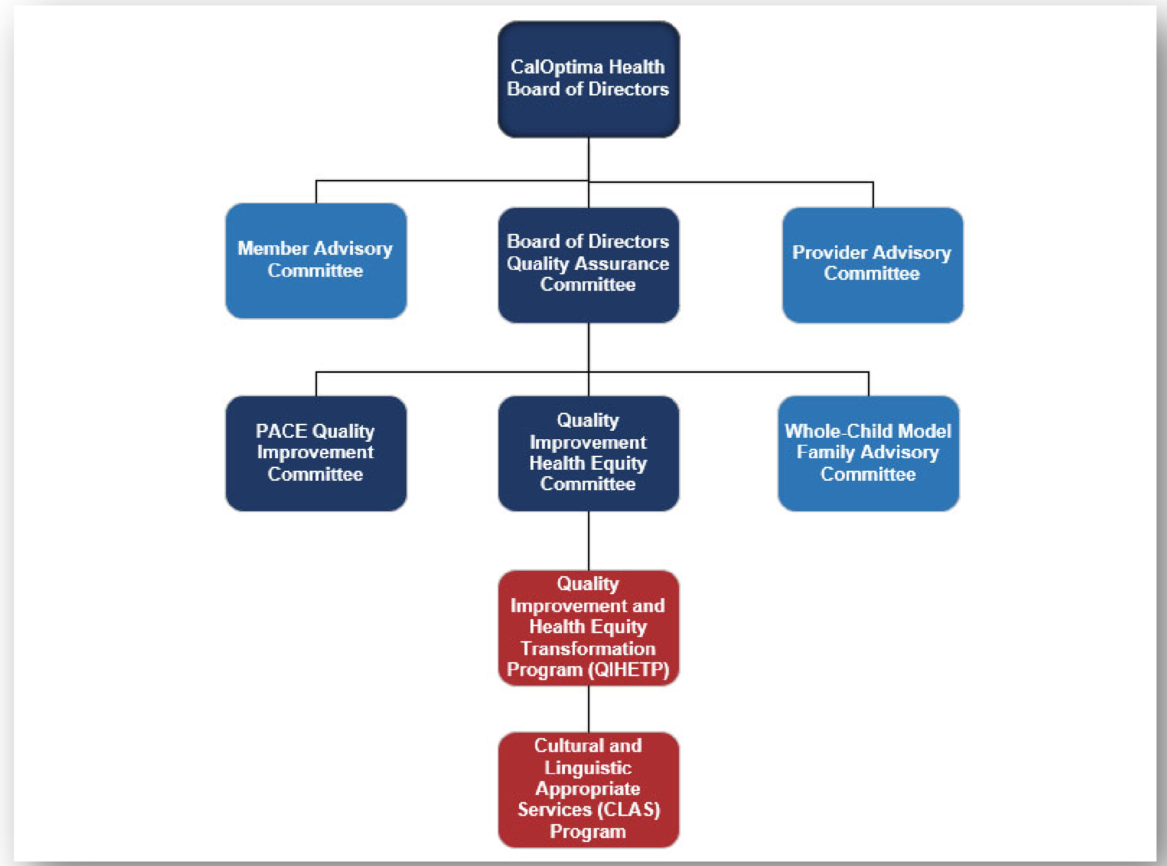
The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI, Health Equity and CLAS contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program, and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated, and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

CLAS Reporting Structure



Community and Member Engagement

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals. The MAC has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services in order to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

MAC represents the diversity of its membership. The following table depicts the current MAC break down by ethnic diversity. MAC includes individuals representing the ethnicity and language groups that represent at least 5% of the population. Please note that as of April 1, 2024, one Family Support Representative and two OneCare member seats remain unfilled and are currently under recruitment.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	46%	Spanish	31%	5	4 OneCare Members 1 Behavioral/Mental Health Representative
White	17%	English	55%	8	1 Adult Beneficiaries 1 Children 1 Foster Children 2 Medi-Cal Beneficiaries or Authorized Family Members 1 Persons with Special Needs 1 Recipients of CalWORKs 1 Seniors
Vietnamese	13%	Vietnamese	9%	1	1 Persons with Disabilities
Korean	3%	Korean	1%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups or meetings and survey, such as implementing a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientation Meetings.

Goals

The following are the goals of the CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate language services experience from members and staff.
3. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
4. Improve practitioner support in providing language services.

CLAS Work Plan

The CLAS Work Plan is a subset of and is imbedded within the QIHETP Work Plan and outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope

- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the CLAS Program and applicable policies and procedures. The 2024 CLAS Work Plan includes all cultural and linguistic focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve collection, storing, retrieval and sharing of race/ethnicity, language, sexual orientation and gender identity data. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans are also publicly available on the CalOptima Health website.

For more details on the 2024 CLAS Work Plan see Appendix A: 2024 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health continuously monitors progress against CLAS goals. At least quarterly, dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes, and outputs. C&L staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at Quality Improvement Health Equity Committee (QIHEC) meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Director's Quality Assurance Committee (QAC).

CLAS Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's CLAS Program are reviewed and evaluated annually by the QIHEC and QAC, as part of the overall CLAS Program Evaluation and approved by the Board of Directors, as reflected in the CLAS Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the CLAS Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

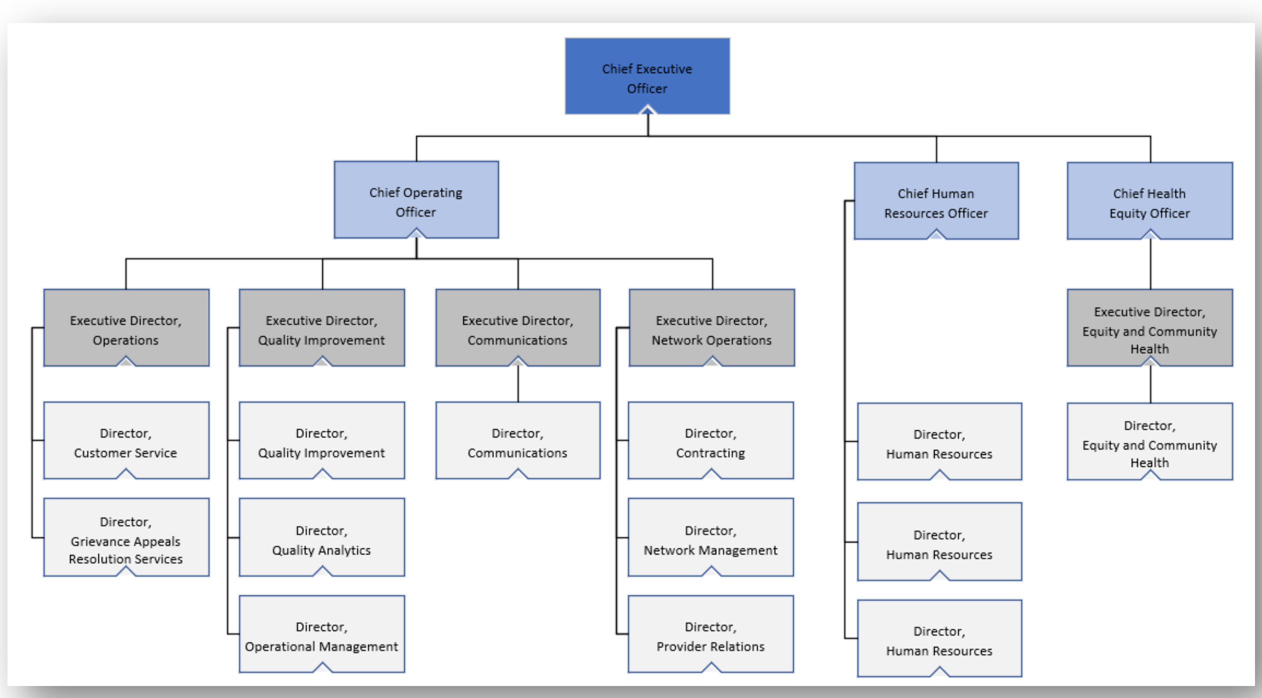
- A description of completed and ongoing CLAS activities that address cultural and linguistic needs or our members, including the achievement or progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of

translation and interpreter services.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs, and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the CLAS Evaluation is also publicly available on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, Manager of Cultural and Linguistics, and nine Program Specialists who are responsible for translation of documents and coordinating cultural and linguistic services with contracted vendors. The Cultural and Linguistics department is supported by CalOptima Health departments including but not limited to:
- Communications
- Contracting
- Customer Service
- Equity and Community Health
- Human Resources
- Network Management
- Provider Relations
- Quality Analytics

Cultural and Linguistic Service Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts; responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, and CalOptima Member Portal.

Director, Grievance Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including to ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Operational Management is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. Interact with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiate provider contracts.

Director, Network Management is responsible for all operational aspects of the Network Management department. The incumbent will oversee the onboarding of all new provider partners, provider data management and analysis and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards; leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of healthcare services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources (Administrative Services) is responsible for leading and overseeing the Human Resources services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer..

Director, Equity and Community Health (ECH) is responsible for program development and implementation for comprehensive population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.

Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services

Language Services

CalOptima Health's Culturally and Linguistically Appropriate Services (CLAS) ensures all members have access to health care related interpreter services in any language and translated member materials in CalOptima's threshold languages.

Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information are available in English, Spanish, Vietnamese, Arabic, Farsi, Korean, and Chinese.
- Provide oral translation for other languages upon request or as needed, by a qualified translator at no cost.

- Provide routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay, or modification of benefits, and the right to file a Grievance or Appeal at no cost.
- Free access to materials in alternative format such as Braille, large print, data, and audio files.
- Free access to 24 hours access to telephonic interpreter services to members with limited English proficiency at no cost.
- Free Remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of-hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

- "Language Interpreting Services" poster in the reception area where members can point to their preferred language
- Member handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New member orientations
- Customer Service Call Center
- Health education workshops
- C&L "We Speak Your Language" brochure
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations (CBOs) and public agencies

CalOptima Health provides informational materials to members written at a no higher than a sixth (6th) grade reading level and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

- Eligible beneficiaries residing in the CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness with:

- Race: any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape;
- Ethnicity: a group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- Culture: the ideas, customs, skills, arts, etc. of a people or group, that are transferred, communicated, or passed along, as in or to succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation, and gender identity.

During onboarding of new employees, on an annual basis, and as needed, CalOptima health ensures CalOptima health staff, Providers, Health Networks, and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Trainings include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new Employee “Boot Camp” C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

Promotion of Diversity

CalOptima Health is committed to reducing bias and improving diversity, equity and inclusion and supports initiatives to recruit, retain and train a diverse healthcare workforce that reflects the cultural and linguistic diversity of the communities serviced. This includes the following:

- Inclusive job descriptions and hiring practices.
- Trainings on the following topics for leaders:
    - Diversity, Inclusion & Conscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Conduct regular pay equity analysis
- Offer benefits and perks to support the diverse needs of employees (ie. Flexible work

arrangements)

Data Collect and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Focused is placed on collecting, storing and retrieving member health care data in order to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identify and sexual orientation.
- Health outcomes
- Language preferences

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance and health care data are stratified by race, ethnicity, language, and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan where progress of planned activities is tracked towards achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

2024 Revised Quality Improvement and Health Equity Transformation Program and Work Plan

Quality Assurance Committee Meeting

June 12, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Revised 2024 Quality Improvement Health Equity Transformation Program (QIHETP) and Annual Work Plan

QIHETP and Work Plan Revisions

- Purpose for Revisions
  - Population Health Management (PHM) Department was renamed to Equity and Community Health (ECH) Department, so the department's name reflects their focus on collaborating/co-designing with the community to develop programs with an "equity lens."
  - Added the Cultural and Linguistic Appropriate Services (CLAS) Program to QIHETP appendix to ensure CalOptima Health continually improves its services to meet the needs of multicultural populations.
    - CLAS is a regulatory requirement (DHCS Contract and NCQA Health Equity Accreditation)
- The following QIHETP Documents were revised:
  - 2024 QIHETP Written Description
  - Appendix: 2024 QIHETP Work Plan
  - Appendix: Cultural and Linguistic Appropriate Services (CLAS) Program (NEW)

2024 Population Health Management (PHM) Strategy and the 2024 Pay-For-Value Program did not require revisions are not presented.

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Updates to the QIHETP Description

- Changed all mention of the PHM Department to the ECH Department:
  - ECH Department role in the QIHETP and Quality Improvement Health Equity Committee (QIHEC), including subcommittees
  - Quality Organization Chart
  - Title and description of positions supporting ECH, such as the Executive Director, Medical Director and Director of Equity and Community Health
- Updated language in the Work Plan to reflect current operations
- Updated the glossary

Cultural and Linguistic Appropriate Services (CLAS) Program

- CLAS Program is part of the appendix of the QIHETP
  - CLAS Work Plan elements are incorporated into the QIHETP Work Plan
  - CLAS Evaluation to be a part of the appendix of QIHETP Evaluation
- Added the CLAS Program Description
  - Our commitment to CLAS
  - Authority and Accountability to the Quality Assurance Committee (QAC) of the Board of Directors
  - CLAS reporting structure to QIHEC
  - Community and Member Engagement through the Member Advisory Committee (MAC)
  - Resources to support CLAS

Cultural and Linguistic Appropriate Services (CLAS) Program

- CLAS Goals
  - Implement a process to collect, store and retrieve member Sexual Orientation and Gender Identify (SOGI) data.
  - Evaluate language services experience from members and staff.
  - Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
  - Improve practitioner support in providing language services.
- Key Business, Processes, Functions and Aspects of CLAS
  - Language Services
  - Cultural Competency and Training
  - Promotion of Diversity
  - Data Collection and Analysis

CLAS Work Plan Elements

2024 QIHETP Work Plan Element Description	Goal(s)
Performance Improvement Project (PIP) Medi-Cal - Increasing W30 6+ measure rate among Black/African American Population	Meet and exceed goals set forth on all improvement projects
Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services
Maternity Care for Black and Native American Persons	Meet the following goals For MY2024 HEDIS: PPC Postpartum: Black 74.74%; Native American 63.22% PPC Prenatal: Black 72.37%; Native American 59.43%
Experience with Language Services	Evaluate language services experience from member and staff
Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.
Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar
5. Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Contacts
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action
Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.

Background
CalOptima Health provides health rewards to members in the form of physical gift cards and plans to explore providing digital e-card and flex card reward options to eligible members to improve member health and quality outcomes. In calendar year (CY) 2024, CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests (multiple), postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication. Member incentives are awarded based on provider attestations using an incentive form and passive rewards based on qualifying claims and encounter data.

Medi-Cal
The Medi-Cal member health rewards program utilizes both provider attestations and passive rewards to issue incentives. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications are historically passively rewarded incentives. The remaining member incentives require a provider attestation.

OneCare
For OneCare members, staff has discussed leveraging a preloaded "flex card" (debit card), to directly reward members for their participation in health rewards program activities. Currently, the OneCare member health rewards program is a passively rewarded program, where members are identified through claims and encounters data and are automatically issued a member health reward. Since there is no provider attestation and form submission required, adapting the reward process to payout through the flex card will increase health reward processing efficiency and minimize turnaround time for members to receive their rewards. CalOptima Health's OneCare flex benefit vendor has the capability to include member health rewards in the flex card for CY 2025. CalOptima Health plans to implement member health rewards in the flex card starting 2025 and will evaluate program effectiveness.

Discussion
Health rewards motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

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Staff recommends maintaining the following health rewards from CY 2024 for CY 2025:

Current	
Medi-Cal	**OneCare**
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Checkup- $50	

Staff also recommends revising the following health rewards for CY 2025. This includes piloting the change from attestation-based to passive identification and rewarding to enhance member experience for Blood Lead Test and to reduce the reward amount from $50 to $25 for Postpartum Checkup to align with other Medi-Cal rewards.

Changes	
Medi-Cal	**OneCare**
Blood Lead Test 12 Months of Age (change rewarding to passive)	N/A
Blood Lead Test 24 Months of Age (change rewarding to passive)	
Postpartum Checkup- $25 (decrease reward value)	

Members will receive health reward gift cards contingent upon completed member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15%* based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings.

**For passive health rewards: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79%, which is the current DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with the current CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People*

with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05%, which is the current DCHS minimum performance level.

Fiscal Impact

Medi-Cal:

The estimated cost for CY 2025 Medi-Cal Member Health Rewards program is $4.87 million. Funding included in the proposed CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program will be sufficient to fund the program.

OneCare:

The estimated cost for CY 2025 OneCare Member Health Rewards program is $660,000 and is a budgeted item in the proposed FY 2024-25 Operating Budget. Management will include expenses for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

1. Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

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Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

June 12, 2024

Linda M. Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Current 2024 Member Health Reward Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- Rewards in the form of retailer physical gift cards
  - Exploring digital e-cards and flex card reward options
- OneCare member health rewards are passively rewarded
  - Reward is based on identified claims and encounters
  - Health Risk Assessment (OC only), Annual Wellness Visit (MC and OC), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (MC only) are passively rewarded.
- Medi-Cal member health rewards are attestation-based
  - Reward is based on provider attestation and form submission

MC: Medi-Cal

OC: OneCare

2024 Program and 2025 Proposed Changes

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Check Up- $25 *Change from $50 to $25	

*Proposed changes for 2025

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2025 Proposed Revisions

- Retain all member health rewards from calendar year 2024 with the following changes:
  - **Blood Lead Test 12 and 24 Months of Age**
    - Pilot to change from attestation-based to passive identification and rewarding to enhance member experience.
  - **Postpartum Checkup**
    - Reduce amount from $50 to $25 reward to align with other Medi-Cal rewards.

Summary of Fiscal Impact

- Estimated Cost at 15% Response Rate*
  - Medi-Cal: approximately $4,870,000
  - OneCare: approximately $660,000

	2024	2025	Budget Difference
Medi-Cal	$4,665,000	$4,865,244	$200,244
OneCare	$530,625	$656,130	$125,505

*For passive rewarded incentives: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79% which is DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05% which is the DHCS minimum performance level.

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Appendix

2025 Proposed Incentives Cost Projections

Member Health Reward	Amount	Medi-Cal Eligible Members	OneCare Eligible Members	Estimated Cost at 5% Response Medi-Cal	Estimated Cost at 5% Response OneCare	Estimated Cost at 15% Response Medi-Cal	Estimated Cost at 15% Response OneCare
Annual Wellness Visit**	$50	198,562	17,233	$496,405	$43,083	$1,489,215[A]	$129,248
Blood Lead Test at 12 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Blood Lead Test 24 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Breast Cancer Screening	$25	78,524	5,466	$98,155	$6,833	$294,465	$20,498
Cervical Cancer Screening	$25	229,229	-	$286,536	-	$859,609	-
Colorectal Cancer Screening	$50	196,563	10,995	$491,408	$27,488	$1,474,223	$82,463
Diabetes A1C Test	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Eye Exam	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications**	$25	1,659	-	$2,074	-	$32,790[G]	-
Follow-up Care for Children Prescribed ADHD Medication	$25	1,265	-	$1,581	-	$4,744	-
Health Risk Assessment	$25	-	17,583	-	$272,537[D]	-	$329,681[E]
Osteoporosis Screening	$25	-	17,233[F]	-	$21,541	-	$64,624
Postpartum Checkup	$25	3,273	-	$4,091	-	$12,274	-
Totals				$1,845,325	$381,353	$4,865,244	$656,130

Eligible members are identified using the February 2024 Prospective Rate HEDIS denominator, but reward is not limited to condition or diagnosis. Annual Wellness Visit, Health Risk Assessment, and Osteoporosis Screening eligible population is based on health reward program eligibility criteria.

**Passive identification and rewarding. (continued next slide)

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2025 Proposed Incentives Cost Projections (Continued)

A. Medi-Cal Annual Wellness Visit goal is 15% response rate.

B. Lead Screening estimated response rate is calculated based on administrative compliance rate for MY2023, 61.06%.

C. Lead Screening estimated response rate is calculated based on minimum performance level for MY2024, 62.79%.

D. Health Risk Assessment estimated for 3 STARs at 62% participation rate.

E. Health Risk Assessment estimated for 4 STARs at 75% participation rate.

F. Osteoporosis Screening eligible population is based on all OneCare members who are eligible and not restricted to specifications dictated in the HEDIS measure requirements for: Osteoporosis Management in Women Who Had a Fracture (OMW).

G. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications Follow-up Care for Children Prescribed ADHD Medication estimated response rate is calculated based on minimum performance level for MY2024, 79.05%.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar
6. Approve Reappointments and Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

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

Recommended Actions
Approve Reappointments and Appointments to the Whole-Child Model Family Advisory Committee as follows:

1. Reappoint the following individuals to each serve a two-year term on the Whole-Child Family Advisory Committee, effective upon Board of Directors approval:
   a. Jessica Putterman as an Authorized Family Member Representative for a term ending June 30, 2026;
   b. Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2026; and
   c. Erika Jewell as a Community Based Organization Representative for a term ending June 30, 2026.

2. Newly appoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval:
   a. Jody Bullard as an Authorized Family Member Representative for a term ending June 30, 2026; and
   b. Jennifer Heavener as a Consumer Advocate Representative for a term ending June 30, 2026.

Background
Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health Board of Directors (Board) established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as Authorized Family Member Representatives and two of whom are designated as Community Based Organization/Consumer Advocate Representatives who represent the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as Community Based Organization/Consumer Advocate Representative seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough Authorized Family Member Representative candidates to fill the nine designated seats.

Discussion
CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations, conducting targeted community outreach to agencies and community-based organizations serving the various open positions, and posting recruitment materials on the CalOptima Health website and CalOptima Health's social media sites, such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2024, five WCM FAC seats will expire: three Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. In addition to the five expiring seats, there is one open seat for an Authorized Family Member Representative to fulfill an existing term, and staff continues to recruit for this important seat.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC members Monica Maier, Sofia Martinez, and Janis Price, evaluated each of the applicants for the current openings. The WCM FAC Nominations Ad Hoc Subcommittee proposed the slate of candidates for the five vacancies and forwarded the recommended slate of candidates for consideration at the June 12, 2024, Quality Assurance Committee meeting.

The candidates for the open positions are as follows:

Authorized Family Member Representatives

Jody Bullard (New Appointment)
Jody Bullard is a former social worker and the current caregiver to her 14-year-old son who was born with a rare genetic syndrome. Prior to leaving employment to become her son's full-time caregiver, Ms. Bullard used her social worker skills for advocating within the CCS system and she would like to assist other WCM participants.

Jessica Putterman (Reappointment)
Jessica Putterman is the mother of a special needs child who currently receives CCS and Medi-Cal services. After 10 years of navigating with her son through CCS, Ms. Putterman would like to assist other parents with her knowledge and expertise in this area, as she has made it a point to learn all that she can to advocate on behalf of her child.

Kristen Rogers (Reappointment)
Kristen Rogers is the mother of a teenager who receives CCS services and is currently a CalOptima member. Ms. Rogers is an active volunteer at Children's Hospital Orange County (CHOC) and has been a member in good standing of the WCM FAC since 2018. Since March 2019, Ms. Rogers has been on the CCS Advisory Group, which meets quarterly in Sacramento, California, where she represents CalOptima and the WCM FAC. Ms. Rogers is currently the WCM FAC Chair and represents the committee at the Family Voices/Lucille Packard Foundation network meetings.

Community-Based Organization Representative

Erika Jewell (Reappointment)

Erika Jewell is the manager of case management and social services at CHOC where she works closely with CHOC Health Alliance and other Medi-Cal patients and families to ensure they receive the social services support they need. Ms. Jewell is a licensed clinical social worker who has worked with CCS patients for over 22 years and participates in local stakeholder groups that benefit CCS patients. She also serves on the Tustin Unified School District's Special Education Advisory Committee. Ms. Jewell serves as the Vice-Chair of the WCM FAC.

Consumer Advocate Representative

Jennifer Heavener (New Appointment)
Jennifer Heavener has been navigating the Medi-Cal and CCS world for the past 20 years with her special needs child, who is a high consumer of medical services. Ms. Heavener's experience as an advocate and caregiver gives her a unique perspective that will help other families with transition through the WCM program. Ms. Heavener has previously served on the WCM-FAC as an Authorized Family Member Representative but would like to continue on the committee as a Consumer Advocate Representative since her son has aged out of CCS and Ms. Heavener is no longer eligible to serve as an Authorized Family Member Representative.

Fiscal Impact
Each WCM FAC member may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the Fiscal Year 2024-25 CalOptima Health Operating Budget.

Rationale for Recommendation
As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancies on the committee. The WCM FAC Nominations Ad Hoc Subcommittee forwards the recommended candidates to the Board of Directors' Quality Assurance Committee for consideration and recommendation to the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments
None

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

7. Ratify Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

Contact

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

Recommended Actions

1. Ratify Calendar Year 2024-A Contract Amendment to the Primary Agreement between the California Department of Health Care Services and CalOptima Health.

Background

As a County Organized Health System (COHS), CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal members in Orange County. In January 2024, CalOptima Health entered into a new Primary and Secondary Agreement with DHCS. Amendments to the new agreements are summarized in the attached appendix, including the new Primary Agreement numbered Agreement 23-30235 and the new Secondary Agreement numbered Agreement 23-30267, which extends the Primary and Secondary Agreements to December 31, 2024. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services. The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement to cover specific Medi-Cal state-supported services to CalOptima Health's members enrolled under the Primary Agreement.

Discussion

Calendar Year (CY) 2024-A Contract Amendment to the Primary Agreement (January 1, 2024 through December 31, 2024)

On December 12, 2023, DHCS provided managed care plans (MCPs), including CalOptima Health, with a draft version of the CY 2024-A Contract Amendment. DHCS indicated that the changes proposed in the CY 2024-A Contract Amendment were not ready when the new 2024 MCP contract was released. This amendment will bring MCP agreements, including CalOptima Health, into alignment with requirements effective January 1, 2024. *See* Attachment 3 for further information regarding the changes contained within this amendment.

The amendment contains notable language changes, and it is worth noting that DHCS has generally already implemented the requirements of the CY 2024-A Contract Amendment by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS' agreements with MCPs, including CalOptima Health. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. While the contractual obligations are retroactive, CalOptima Health staff has implemented the required operational changes and other contractual requirements by following the DHCS APLs and sub-regulatory guidance.

DHCS provided the finalized amendment to CalOptima Health for signature on Wednesday, May 15, 2024. DHCS requested that CalOptima Health sign and return the amendment no later than Thursday, May 30, 2024. In order to meet DHCS' deadline, CalOptima Health procured the Chair's signature on Thursday, May 23, 2024, and returned the signed amendment to DHCS. As such, staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendment with the DHCS.

The amendment does not contain any rate changes or otherwise set any new rates. Staff received finalized CY 2024 rates from the DHCS in December 2023 via a separate amendment and received authority to execute that amendment during the March 7, 2024, meeting of the Board of Directors.

Fiscal Impact

The recommended action is expected to be budget neutral. Staff have already included the estimated Medi-Cal revenue and expenses in the Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

CalOptima Health's execution of the CY 2024-A Contract Amendment to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1_Appendix Summary of Agreement Amendments with DHCS
2. Attachment 2_CY 2024-A CalOptima Health Contract Amendment (Primary Agreement + Amendments)
3. Attachment 3_Additional CY 2024-A Contract Amendment Detail

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

APPENDIX TO AGENDA ITEM 7

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011

Amendments to Primary Agreement	Board Approval
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)**-**compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014

Amendments to Primary Agreement	Board Approval
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020

Amendments to Primary Agreement	Board Approval
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023

Amendments to Primary Agreement	Board Approval
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension)

	Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023

A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

Exhibit A
SCOPE OF WORK

I. Service Overview

Contractor agrees to provide to the California Department of Health Services (DHCS) the following services described herein:

Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the Contract.

II. Service Location

The services must be performed at all contracting and participating facilities of Contractor.

III. Service Hours

The Services must be provided as needed on a 24-hour, seven days a week basis.

IV. Contract Representatives

A. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Chief, Procurement & Contract Development Branch Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba: CalOptima Health Attention: Michael Hunn, CEO Telephone: (657) 900-1481 Fax: (714) 481-6498 Email: Michael.hunn@caloptima.org

B. Direct all inquiries to:

Exhibit A
SCOPE OF WORK

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 P.O. Box Number 997413, Mail Stop 4408 Sacramento, CA 95899-7413 Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba: CalOptima Health Attention: Michael Wood, Manager, Regulatory Affairs & Compliance 505 City Parkway West Orange, CA, 92868 Telephone: (714) 246-8415 Fax: (714) 246-6418 Email: mwood@caloptima.org

C. Either party may make changes to the information in provision 4 of this Exhibit A by giving written notice to the other party. Said changes must not require an amendment to this Contract.

V. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (ADA) (42 USC sections 12101, *et seq.*), as amended, and regulations implementing those statutes as set forth in 36 Code of Federal Regulations (CFR) part 1194 and 28 CFR part 36, as applicable. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 7405 codifies section 508 of the Rehabilitation Act (29 USC section 794d) and the regulations implementing the Rehabilitation Act at 36 CFR part 1194, requiring accessibility of EIT.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Exhibit A, ATTACHMENT I

1.0 Definitions

As used in this Contract, unless otherwise expressly provided ~~or the context otherwise requires,~~ the following definitions of terms governs the construction of this Contract:

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Admission, Discharge, and Transfer (ADT) Feed means a standardized data feed, updated consistently in real-time sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare Encounter Data at time of admission, discharge, and/or transfer from the facility. Demographic information within the feed must meet requirements of the most recent version of the California Data Exchange Framework's Technical Requirements for Exchange Policy and Procedure and conform to United States Core Data for Interoperability (USCDI) requirements of the California Data Exchange Framework.

Administrative Cost means only those cost that arise out of Contractor's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Subcontractor means a Subcontractor that contractually assumes administrative obligations of Contractor under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination are not administrative functions.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities, and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, whether statutory or as recognized by the California courts, relating to the provision of health care when a Member is incapacitated.

Adverse Benefit Determination (ABD) means any of the following actions taken by Contractor:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, ~~appropriateness, setting, or effectiveness of a Covered Service~~;

B. The reduction, suspension, or termination of a previously authorized Covered Service;

C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an ABD;

D. The failure to provide Covered Services in a timely manner;

E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;

F. The denial of the Member's request to obtain services out-of-Network when a Member is in an area with only one Medi-Cal managed care health plan; or

G. The denial of a Member's request to dispute financial liability.

Affiliate means an entity or an individual that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control of Contractor and that provides services to or receives services from Contractor.

All Plan Letter (APL) or **Policy Letter (PL)** means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists and nurses.

Alternative Format Selection (AFS) means the choice a Member or a Member's Authorized Representative (AR) makes to receive information and materials in an alternate format, such as braille, large font, and electronic media, including audio or data compact discs.

American Indian means a Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

Appeal means a review by Contractor of an Adverse Benefit Determination (ABD) which includes one of the following actions:

A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B. A reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;

D. Failure to provide services in a timely manner; or

E. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

Application Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Asthma Preventive Services (APS) is defined as **a service that provides** information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms. Asthma Preventive Services includes evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma.

Authorized Representative (AR) means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Auxiliary Aid means "auxiliary aids and services" as defined in 28 CFR section 36.303(b) that assist disabled Members to communicate, receive and understand information.

Basic Population Health Management (Basic PHM) means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Behavioral Health means mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional, or QAS Paraprofessional.

Beneficiary Identification Card means a plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Bright Futures Periodicity Schedule means the *Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care* and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance with which all Members less than 21 years of age must receive well child assessments, screenings, and services.

California Advancing and Innovating Medi-Cal (**CalAIM) Terms and Conditions** means those terms and conditions issued and approved by the federal Centers for Medicare & Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code (W&I). CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

A. CalAIM Demonstration, Number 11-W-00193/9, as approved by CMS pursuant to 42 United States Code (USC) section 1315, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

B. Any associated Medicaid waivers as approved by CMS pursuant to 42 USC section 1396n, including but not limited to the CalAIM Section 1915(b) Waiver

Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS)-Eligible Condition means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 *et seq*.

CCS Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the California Children's Services (CCS) Program.

CCS Program means a State and county program providing Medically Necessary services to treat California Children's Services (CCS)-Eligible Conditions.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member for each month the Member is enrolled with Contractor that is based on the actuarially sound capitation rate for the provision of Covered Services and paid regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means Contractor's coordination of care delivery and services for Members, either within or- across delivery systems including:

A. Services the Member receives by Contractor;

B. Services the Member receives from any other managed care health plan;

C. Services the Member receives in Fee-For-Service (FFS);

D. Services the Member receives from out-of-Network Providers;

E. Services that the Member receives through carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and

F. Services the Member receives from community and social support Providers.

Care Management Plan (CMP) means a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.

Center of Excellence means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Certified Nurse Midwife (**CNM**) means a registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.

Child/Children, regardless of whether the term is capitalized or not, means a Member/Members less than 21 years of age unless otherwise specified.

Children with Special Health Care Needs (CSHCN) means Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by Children generally. The identification, assessment, treatment, and coordination of care for CSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) – (4).

Clean Claim means a claim that can be processed without obtaining additional information from the Provider or from a third party, including bills, or invoices that meet DHCS established billing and invoicing requirements.

Cold-Call Marketing means Contractor's or its agent's unsolicited personal contact with a Member or a Potential Member for the purpose of Marketing.

Community Based Adult Services (CBAS) means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the CalAIM Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

CBAS Discharge Plan of Care means a discharge plan of care based on the Member's Community Based Adult Services (CBAS) assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

CBAS Emergency Remote Services (ERS) means the following services, provided in alternative Service Locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

CBAS Individual Plan of Care (IPC) means a written plan of care developed by a Community Based Adult Services (CBAS) center's multidisciplinary team, as specified in the CalAIM Terms and Conditions, or as specified in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

CBAS Provider means an Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health (CDPH) to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Health Assessment (CHA) means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

Community Health Improvement Plan (CHIP) means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for Public Health Accreditation Board (PHAB) accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.

Community Health Worker (CHW) means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

Community Reinvestment Plan means a document outlining the reinvestment activities in local communities.

Community Supports means substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent

with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees)*.

Complex Care Management (CCM) means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for chronic conditions and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

CCM Care Manager means an individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Confidential Information means facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.

Contract means this written agreement between DHCS and Contractor.

Contract Revenues means the amount of Medi-Cal managed health care Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Contractor's Representative means an individual appointed by Contractor who is responsible for implementing this Contract, receiving notices on this Contract, and taking actions and making representations related to the compliance with this Contract.

Correctional Facility means State prisons, county jails, and youth correctional facilities.

Corrective Actions means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

Cost Avoid or **Cost Avoidance** means the practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

County Social Services Department means a county agency responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program or for providing services as specified in this Contract.

Covered Services means those health care services, set forth in W&I sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver

authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Covered Services do not include:

A. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (*Services for Persons with Developmental Disabilities*), 4.3.20 (*Home and Community-Based Services Programs*) regarding waiver programs, 4.3.21 (*In-Home Supportive Services*), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11.F.4 (*Targeted Case Management Services*), regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services;

B. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), except for Contractors providing Whole Child Model (WCM) services;

C. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*);

D. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*);

E. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*);

F. Direct Observed Therapy for Treatment of Tuberculosis as specified in Exhibit A, Attachment III, Subsection 4.3.18 (*Direct Observed Therapy for Treatment of Tuberculosis*);

G. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*) regarding dental services;

H. Prayer or spiritual healing as specified in 22 CCR section 51312;

I. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (*School-Based Services*);

J. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH);

K. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

N. Childhood lead poisoning case management provided by county **or State** health departments;

O. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

P. End of life services as stated in Health and Safety Code (H&S) section 443 *et seq*., and APL 16-006; and

Q. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.

Credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Deemed Exhaustion means Contractor's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), which allows a Member to immediately request a State Hearing.

Department of Health Care Services (DHCS) or **Department** means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

DHCS Comprehensive Quality Strategy means the federally required written strategy produced by the State, pursuant to 42 CFR section 438.340 that assesses and improves the quality of health care and services furnished by Medi-Cal managed care health plans.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for this Contract, and responsible for receiving and sending notices and other documents from/to Contractor relating to this Contract.

DHCS Contracting Officer means the DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under this Contract.

Department of Managed Health Care (DMHC) means the California department responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

Director means the Director of DHCS.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Discharge Planning means planning that begins at the time of admission to a hospital or facility to ensure that necessary care, services, and supports are in place in the

community before a Member leaves the hospital or facility in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Discrimination Grievance means any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135, and federal non-discrimination law, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Doula means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in APL 23-024.

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Administrative Subcontractor means a Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Subcontractor Agreement means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Durable Medical Equipment (DME) means Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.

Dyadic Care means to serve both parent(s) or caregiver(s) and Child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy Child development and mental health. It is provided within pediatric Primary Care settings whenever possible and can help identify Behavioral Health interventions and other Behavioral Health issues, provide referrals to services, and help guide the parent-Child or caregiver-Child relationship. Dyadic Care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric Preventive Care.

Dyadic Service means a family and caregiver-focused Model of Care intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic Services include Dyadic Behavioral Health (DBH) well-Child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq.*, and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be

Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:

A. Placing the Member's health in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious dysfunction to any bodily organ or part; or

D. Death.

Emergency Medical Transportation (EMT) means transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan means the plan identified and described in Exhibit A, Attachment III, Section 6.1 (*General* ~~Guidance~~ ***Requirements***).

Emergency Services means inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter means an instance of direct Provider-to-Member interaction, regardless of the setting, where the Provider is diagnosing, evaluating, or treating the Member's condition.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this Contract and subject to the standards of 42 CFR sections 438.242 and 438.818.

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Lead Care Manager means a Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as

staff of Contractor, and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Populations of Focus/Populations of Focus means the populations identified in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).

Enrollment means the process by which a Potential Member becomes a Member of Contractor.

Excluded Entities or **Excluded Providers** means entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid Fraud.

Excluded Service means a service that is covered by the Medi-Cal program but is not a Covered Service, and is carved out of this Contract for the provision of Covered Services.

External Quality Review (EQR) means the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR-related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Family Therapy means a type of psychotherapy covered under the Medi-Cal Non-specialty Mental Health Services (NSMHS) benefit and is composed of at least two family members. Family therapy sessions address family dynamics as they relate to mental status and behavior(s) and is focused on improving relationships and behaviors in the family and between family members, such as between a Child and parent(s) or caregiver(s).

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) means an entity defined in 42 USC section 1396d(l)(2)(B).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.

Fee-For-Service (FFS) means the Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal Covered Services rendered to Medi-Cal recipients.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than three full months' capitation.

Financial Statements means reports prepared by Contractor to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30; the federal Fiscal Year (FY) is October 1 through September 30.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

Freestanding Birthing Center (FBC) means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(l)(3)(B).

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Governing Board means Contractor’s board of directors or a similar body, and/or its executive management, that has the authority to manage and direct Contractor’s affairs and activities, including, but not limited to, approving initiatives and establishing Contractor's policies and procedures.

Grievance means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Contractor’s employee, failure to respect a Member’s rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Contractor processes. If contractor is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.

Health Disparity means differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation, gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity means a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Healthcare Effectiveness Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Implementation Period means the period of time in which Contractor is undertaking any readiness requirements required by DHCS before performance of the Contract begins. The Implementation Period begins with DHCS awarding this Contract and extends to the effective date that begins the Operations Period.

Incentive Arrangement means any payment mechanism approved by Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to

Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Subsection 1.1.14.D (*Special Contract Provisions Related to Payment*).

Independent Medical Review (IMR) means a review of Contractor's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on Contractor but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.

Indian Health Service (IHS) means an agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations and provides them with a comprehensive Indian health care delivery system.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA) means an Indian Health Service (IHS) program funded under the authority of Public Law 93-638 at 25 USC section 5301 et seq. These programs have elected to participate in Medi-Cal as IHS/MOA providers. IHS/MOAs are subject to the payment terms of APL 17-020. The list of eligible IHS/MOA providers is found in APL 17-020, Attachment #1. These providers receive a federally established All-Inclusive Rate that is updated annually by the federal Office of Management and Budgets and published in APL 17-020, Attachment #2.

In-Home Supportive Services (IHSS) means services provided to Members by a county in accordance with the requirements set forth in W&I sections 12300 *et seq.*, 14132.95, 14132.952, and 14132.956.

Initial Health Appointment (IHA), previously called Initial Health Assessment, means an assessment that must be completed within 120 days of Contractor enrollment for new Members and must include a history of the Member's physical and Behavioral Health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

Incurred but Not Reported (IBNR) Claim Estimate means a financial accounting of all services that have been performed, but have not been invoiced or recorded, or

estimates of costs for medical services provided for which a claim has not yet been filed.

Intermediate Care Facility (ICF) means a residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212. **An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types:**

A. ICF/DD-Habilitative as defined in Health and Safety Code (H&S) section 1250(e);

B. ICF/DD-Nursing as defined in H&S section 1250(h); and

C. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD-Continuous Nursing Care Program.

Joint Commission (JC) means the organization that provides health care accreditation and related services that support performance improvement in health care organization and is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.

Justice Involved (JI) Individuals means individuals who are currently incarcerated, or were formerly incarcerated within the past 12 months.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) means the law that regulates health care service plans and is administrated by DMHC, commencing with H&S section 1340 *et seq*.

Laboratory Testing Site means any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Licensed Midwife (LM) means an individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions Code (B&P) section 2507.

Limited English Proficiency (LEP) means an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor’s employees.

Local Educational Agency (LEA) means a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) means a local governmental entity including, but not limited to, a county Child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district, or county office of education.

Local Health Department (LHD) means a municipal, county, or regional public health department.

Long-Term Care (LTC) means specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services.

Marketing means any activity conducted by or on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade or influence Potential Members to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of Contractor that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos, and media scripts.

Marketing Representative means a person who is engaged in Marketing activities on behalf of Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by DHCS which provides on-line access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal FFS Rate means the rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Provider Manual means the multi-part document identifying Medi-Cal benefits and billing codes published and maintained by DHCS at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx.

Medical Home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medical Records means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary

services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Member or **Enrollee** means a Potential Member who has enrolled with Contractor.

Member Assignment means the written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member's choice, or if as designated by DHCS when the Potential Member fails to make a timely choice.

Member Handbook or **Evidence of Coverage (EOC)** means the document that describes the health care benefits and Covered Services that are available to a Member.

Member Information means documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory,

welcome packets, Marketing information, form letters including Notice of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Memorandum of Understanding (MOU) means a formal written agreement between Contractor and Local Government Agencies, county programs, and third-party entities.

Minimum Performance Level (MPL) refers to Contractor's minimum performance requirements for select Quality Performance Measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations:

A. Sexual assault, including rape;

B. Drug or alcohol abuse for minors 12 years of age or older;

C. Pregnancy;

D. Family planning;

E. Sexually transmitted diseases (STDs) in minors 12 years of age or older;

F. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and

G. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.

Model of Care (MOC) means Contractor's framework for providing Enhanced Care Management (ECM) and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

National Committee for Quality Assurance (NCQA) is an organization responsible for the accreditation of managed care plans and other health care entities and for

developing and managing health care measures that assess the Quality of Care and services that Members receive.

National Provider Identifier (NPI) means a unique identification number for Providers. Contractor must use the NPIs in the administrative and financial transactions adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Network means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.

Network Provider Data means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream

Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used 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, and pursuant to 22 CCR sections

51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Medical Transportation (NMT) means transportation of Members to obtain Covered Services or Excluded Services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

A. Mental health evaluation and treatment, including individual, group and family psychotherapy;

B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;

C. Outpatient services for the purposes of monitoring drug therapy;

D. Psychiatric consultation; and

E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Operations Period means the period of time between the effective date of the first month of operations and continues on through the last month of Contractor's capitation and provision of services to Members. The Operations Period commences at the conclusion of the Implementation Period upon DHCS' acceptance of Contractor's completion of any readiness requirements required by DHCS.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.

Partially Delegated Subcontractor means a Subcontractor that contractually assumes some, but not all, duties and obligations of Contractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Pass-Through Payment means the “Pass-through payment,” as defined in 42 CFR section 438.6(a), that has been documented in a rate certification approved by the federal Centers for Medicare & Medicaid Services (CMS).

Phaseout Period means the period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized screening, assessment processes, and holistic care/case management interventions.

Population Health Management (PHM) Service means a service that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

Population Health Management Strategy (PHMS) means~~ a comprehensive plan of action for addressing Member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. Contractor is required to include, at a minimum, a description of how it will:~~

~~A. Keep all Members healthy by focusing on wellness and prevention services;~~

~~B. Identify and manage Members with high and rising-risk;~~

~~C. Include a separate section on Members less than 21 years of age;~~

~~D. Ensure effective transition planning across delivery systems or settings through Care Coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and~~

~~E. Identify and mitigate Member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance Health Equity.~~
an annual deliverable that Contractor must submit to DHCS requiring Contractor to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

Population Needs Assessment (PNA) means a **multi-year** process ~~for:~~

~~A. Identifying Member health needs and Health Disparities;~~

~~B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and~~

~~C. Implementing targeted strategies for health education, C&L, and QI programs and services.~~
during which Contractor will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform Contractor's annual PHM Strategy.

Post-Payment Recovery (PPR) means Contractor's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.

Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member's condition.

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2V, 30, 32, 33, 34, 35, , 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J,	03, 04, 06, 07,2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76

	7S, 7W, 7X, 82, 86, 8E, 8P, 8R, 8U, E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	
Adult & Family/Optional Targeted Low-Income Child Dual Eligible	0A, 0E, 2C, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 7X, 82, 8E, 8P, 8R, 8U, E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD Dual	10, 14, 16,1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long-Term Care	13, 23, 53, 63	
Long-Term Care Dual	13, 23, 53, 63	

Prescription Drug means a drug or medication that can only be accessed through a Provider’s prescription.

Preventive Care means health care designed to prevent disease, illness, injury, and/or its consequences.

Primary Care means health care usually rendered in ambulatory settings by Primary Care Providers (PCP) and mid-level practitioners that emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner,

non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Program Data means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-Network request data, and Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Provider means 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.

Provider Directory means Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

Provider Dispute Resolution Mechanism means Contractor's obligation to include a timely, fair, and cost-effective dispute resolution process where Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers can submit disputes.

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR section 447.26(b).

Qualified Autism Services (QAS) Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the California Medicaid State Plan, who provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Provider means a licensed practitioner or Board-Certified Behavior Analyst (BCBA) who designs, supervises, or provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Quality Improvement and Health Equity Committee (QIHEC) means a committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP) means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.

Quality Measure Compliance Audit means a thorough assessment of Contractor's information system capabilities and compliance with each Healthcare Effectiveness Data and Information Set (HEDIS®) specification to ensure accurate, reliable, and publicly reportable data.

Quality of Care means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.

Quality Performance Measures means tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Quantitative Treatment Limitation (QTL) means a limit on the scope or duration of a Covered Service that is expressed numerically.

Rating Period means a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR section 438.7(a).

Regional Center (RC) means a non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases, and manages services for Members with Developmental Disabilities and their families.

Restricted Provider Database (RPD) means the database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible allegation of Fraud, or Providers who are placed on

a temporary or indefinite Medi-Cal suspension while under investigation for Fraud or Abuse, or Enrollment violations.

Retrospective Review means the process of determining Medical Necessity after treatment has been given.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the CMS-approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

Risk Stratification and Segmentation (RSS) means the process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS results in the categorization of Members with care needs at all levels and intensities.

Risk Tiering means the assigning of Members to standard Risk Tiers (low, medium-rising, or high), with the goal of determining appropriate care management programs or specific services.

Rural Health Clinic (RHC) means an entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety-Net Provider means any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.

School Site means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School Site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Senior and Person with Disability (SPD) means a Member who falls under a specific SPD aid code as defined by DHCS.

Service Area means the county or counties that Contractor is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains Covered Services under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, geographic Service Area, composition of payments to its Network, or Enrollment of a new population.

Site Review means surveys and reviews conducted by DHCS or Contractor to ensure that Network Provider, Subcontractor, and Downstream Subcontractor sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, State, and local laws and regulations.

Skilled Nursing Care means Covered Services provided by nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Social Drivers of Health (SDOH) means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.

Special Care Center means a center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Specialist means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I section 14197.

Specialty Mental Health Provider means a person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service (SMHS) means a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary Specialty Mental Health Services.

Standing Referral means a referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State means the State of California.

State Hearing means a hearing with a State Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

State Supported Services means Medi-Cal services that are funded entirely by the State, and for which the State does not receive matching federal funds. These services are covered by Contractor through their Secondary Contract with DHCS for State Supported Services.

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider means a Provider that renders Street Medicine services as offered by Contractor to their Members. Street Medicine Providers may provide services in various roles, such as the Member's assigned Primary Care Provider (PCP), through a direct contract with the Contractor, as an Enhanced Care Managed (ECM) Provider, as a Community Supports Provider, or as a referring or treating contracted Provider as set forth in APL ~~22-023~~**24-001**.

Subacute Care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of Members in a Skilled Nursing Facility (SNF), as defined in 22 CCR section 51124.5.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's

obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

Subcontractor Network means a Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

Substance Use Disorder (SUD) means those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Section 1.7 (*Supplemental Payments*) of this Contract.

Suspended and Ineligible Provider List means the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using 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 a separate location from the Provider.

Template Data means data reports submitted to DHCS by Contractors, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

Third Party Tort Liability (TPTL) means the contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages means the non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.

Transitional Care Service means a service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

Treatment Authorization Request (TAR) means certain Fee-For-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Tribal Federally Qualified Health Center (Tribal FQHC) means a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in Medi-Cal Tribal FQHCs and are subject to the payment terms of APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in APL 21-008, Attachment #1. A list of Tribal FQHCs is published in APL 21-008, Attachment #2.

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

United States Department of Health and Human Services (U.S. DHHS) means the federal agency that oversees Centers for Medicare & Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Urban Indian Organization means a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Utilization Management (UM) or **Utilization Review** means the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Vaccines for Children (VFC) Program means the federally funded program that provides free vaccines for eligible Children age 18 or younger (including all Medi-Cal eligible Children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Waste means the overutilization or inappropriate utilization of services and misuse of resources.

Withhold Arrangement means any payment mechanism approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which a portion of a capitation rate is withheld from Contractor, with a portion or all of the withheld amount to be paid to Contractor for meeting targets specified in this Contract, including but not limited to Exhibit B, Subsection 1.1.14.E (*Special Contract Provisions Related to Payment*).

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Day(s) means Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page.

"Your Rights" Attachment means Contractor's written notice sent to the Member that explains the Member's rights to challenge, free of charge, Contractor's action, and the Member's right to file an Appeal with Contractor, a Deemed Exhaustion, and the right to request a State Hearing or an Independent Medical Review (IMR).

2.0 Acronyms

Medi-Cal Managed Care Contract Acronyms List

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following acronyms are abbreviations for the corresponding terms. This Acronyms List is provided for the convenience of the parties and must not be deemed as an exhaustive or exclusive list of all acronyms in this Contract. In the event that the acronyms contained in this list are inconsistent with the provisions in the Contract, the Contract provisions will prevail.

Acronyms	Corresponding Terms
AAP	American Academy of Pediatrics
ABD	Adverse Benefit Determination
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetrician and Gynecologists
ADA	Americans with Disabilities Act of 1990
ADHC	Adult Day Health Care
ADO	Alternate Dispute Officer
ADT	**Admission, Discharge, and Transfer**
AFS	Alternative Format Selection
AIDS	Acquired Immune Deficiency Syndrome
APL	All Plan Letter
API	Application Programming Interface
APS	Asthma Preventive Service
AR	Authorized Representative
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
Basic PHM	Basic Population Health Management
BHT	Behavioral Health Treatment
C&L	Cultural & Linguistic
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community Based Adult Services
CB-CME	Community-Based Care Management Entities
CCM	Complex Care Management
CCR	California Code of Regulations
CCS	California Children’s Services
CDPH	California Department of Public Health
CFR	Code of Federal Regulations
CHA	**Community Health Assessment**

Acronyms	Corresponding Terms
CHIP	**Community Health Implementation Plan**
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Act
CLPPB	Childhood Lead Poisoning Prevention Branch
CMP	Care Management Plan
CMS	The Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBA	Coordination of Benefits Agreement
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRC	Caregiver Resource Center
CSHCN	Children with Special Health Care Needs
DDS	Department of Developmental Services
DF	Disclosure Form
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMFEA	Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse
DMHC	Department of Managed Health Care
DOT	Direct Observed Therapy
D-SNP	Dual-Eligible Special Needs Plan
DUR	Drug Use Review
DVBE	Disabled Veteran Business Enterprises
ECM	Enhanced Care Management
EMT	Emergency Medical Transportation
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERS	CBAS Emergency Remote Services
FBC	Freestanding Birthing Centers
FDA	United States Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FSR	Facility Site Review

Acronyms	Corresponding Terms
GAAP	Generally Accepted Accounting Principles
GC	California Government Code
H&S	Health and Safety Code
HCBS	Home and Community-Based Services
HCO	Health Care Options
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPA	Health Plan Accreditation
ICD-10	International Classification of Diseases, Tenth Revision
ICF/DD	Intermediate Care Facility Developmentally Disabled
ICF/DD-H	Intermediate Care Facility/Developmentally Disabled Habilitative
ICF/DD-N	Intermediate Care Facility/Developmentally Disabled Nursing
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHA	Initial Health Appointment
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IHSP	Individualized Health and Support Plan
IHSS	In-Home Supportive Services
IMD	Institution for Mental Diseases
IMR	Independent Medical Review
IPA	Independent Physician/Provider Associations
IPC	Individual Plan of Care
IT	Information Technology
JC	Joint Commission
JI	**Justice Involved**
KKA	Knox-Keene Health Care Service Plan Act of 1975
LEA	Local Education Agency
LEP	Limited English Proficiency
LGA	Local Government Agency
LHD	Local Health Department
LM	Licensed Midwife
LTC	Long-Term Care
LTSS	Long-Term Services and Support

Acronyms	Corresponding Terms
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)
MCH	Maternal and Child Health
MEDS	Medi-Cal Eligibility Data System
MFTP	Money Follows the Person
MHP	County Mental Health Plan
MIS	Management and Information System
MLR	Medical Loss Ratio
MOC	Model of Care
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Service Program
NABD	Notice of Adverse Benefit Determination
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NISTSP	National Institute of Standards and Technology Special Publication
NMT	Non-Medical Transportation
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NSMHS	Non-specialty Mental Health Service
OHC	Other Health Coverage
PACE	Program for All-Inclusive Care for the Elderly
PCC	California Public Contract Code
PCP	Primary Care Provider
PHI	Protected Health Information
PHM	Population Health Management
PHMS	Population Health Management Strategy
PI	Personal Information
PIA	Prison Industry Authority
PIP	Performance Improvement Project
PIR	Privacy Incident Reporting
PIU	Program Integrity Unit
PL	Policy Letter
PNA	Population Needs Assessment

Acronyms	Corresponding Terms
PPC	Provider-Preventable Condition
PPR	Post-Payment Recovery
PSCI	Personal, Sensitive, and/or Confidential Information
QAS	Qualified Autism Services
QI	Quality Improvement
QIHEC	Quality Improvement and Health Equity Committee
QIHETP	Quality Improvement and Health Equity Transformation Program
QSO	Qualified Service Organization
QTL	Quantitative Treatment Limitation
RC	Regional Center
RHC	Rural Health Clinic
RPD	Restricted Provider Database
RSS	Risk Stratification and Segmentation
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Drivers of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPD	Senior and Person with Disability
STC	Special Terms and Conditions
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunication Devices for the Deaf
TNE	Tangible Net Equity
TPTL	Third Party Tort Liability
TTY	Telephone Typewriters
U.S. DHHS	United States Department of Health and Human Services
UM	Utilization Management
US DOJ	United States Department of Justice
USC	United States Code
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children
W&I	Welfare and Institutions Code

Acronyms	Corresponding Terms
WCM	Whole Child Model
WIC	Women, Infants and Children Supplemental Nutrition Program

Exhibit A, ATTACHMENT II

1.0 Operational Readiness Deliverables and Requirements

This Article describes a non-exhaustive list of Contractor deliverables, activities, and timeframes to be completed during the Implementation Period before beginning the Operations Period.

Upon successful completion of operational readiness deliverables and requirements, DHCS will provide Contractor a written authorization to begin its Operations Period. The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period.

Once the Contract is awarded, DHCS will provide Contractor with a timeline to complete Implementation Period deliverables and requirements. The table in this Article must not be deemed as exhaustive, exclusive, or limiting. Contractor must submit all required operational deliverables consistent with all requirements set forth in this Contract on a schedule, form, and manner specified by the DHCS. Contractor may be responsible for additional deliverable requirements or activities during the Implementation Period based on changes in State and federal law and/or DHCS program needs. Contractor must comply with any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS.

In the event Contractor fails to submit all deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Liquidated Damages and Sanctions in accordance with Exhibit E, Sections 1.19 (*Sanctions*) and 1.20 (*Liquidated Damages*).

Dual Special Needs Plan

Contractors in Coordinated Care Initiative counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties) must have a Dual Special Needs Plan (D-SNP) available to dual eligible Members for contract year 2024 and must provide documentation of the Centers for Medicare & Medicaid approval of the D-SNP by December 2, 2023.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT II –1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

Identifier	Operational Readiness Requirement
R.0001	Submit documentation of State employees (current and former) who may present a conflict of interest as defined in Exhibit A, Attachment III, Subsection 1.1.3 (*Conflict of Interest – Current and Former State Employees)*.
R.0002	Submit a complete organizational chart.
R.0003	If Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.
R.0004	Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.
R.0005	Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's public policy advisory committee.
R.0006	Submit the Knox-Keene license exhibits and forms reflecting current operation status, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*) and 28 California Code of Regulations (CCR) section 1300.51.
R.0007	Submit supporting documentation if Contractor is not currently licensed to operate in an awarded Service Area, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*).
R.0008	If, within the last five years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor must submit a summary of the circumstances surrounding the termination or non-renewal, a description of the parties involved, including address(es) and telephone number(s). Describe Contractor's Corrective Actions to prevent future occurrences of any problems identified.
R.0009	Identify the composition and meeting frequency of any committee participating in establishing Contractor's public policy including the percent of patient/Member consumers. Describe Contractor's Governing Board, including the percent of patient/Member consumers, the frequency of the committee's report submission to Contractor's Governing Board, and the Governing Board's process for handling reports and recommendations after receipt.

Identifier	Operational Readiness Requirement
R.0010	Contractor must submit policies and procedures for ensuring that all appropriate staff and Network Providers receives annual diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) relating to Members including completion of required Continuing Medical Education on cultural competency/humility and implicit bias.

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

Identifier	Operational Readiness Requirement
R.0012	Submit most recent audited annual financial reports.
R.0013	Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
R.0014	Submit the Knox-Keene license exhibits reflecting projected financial viability as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.76.
R.0015	Submit Knox-Keene license Exhibit HH-6 as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.51(d)(HH).
R.0016	1) Describe any risk sharing or Incentive Arrangements. 2) Explain any intent to enter into a stop loss option with DHCS. 3) Describe any reinsurance and risk-sharing arrangements with any Subcontractors and Downstream Subcontractors shown in this Contract. 4) Submit copies of all policies and agreements. 5) Comply with assumption of financial risk and reinsurance requirements pursuant to 22 CCR sections 53863 and 53868. Comply with directed payments requirements pursuant to 42 Code of Federal Regulations (CFR) section 438.6.
R.0017	Fiscal Arrangements: Submit the Knox-Keene license exhibits as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 28 CCR section 1300.51.
R.0018	Describe systems for ensuring that Subcontractors, Downstream Subcontractors, and Network Providers who are providing services to Medi-Cal Members, have the administrative and financial capacity to meet its contractual obligations and requirements, as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 22 CCR section 53250 and 28 CCR section 1300.70.

Identifier	Operational Readiness Requirement
R.0019	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
R.0020	Describe process to ensure timely filing of required financial reports as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*). Contractor must also describe how it will comply with the Administrative Cost requirements referenced in 22 CCR section 53864(b).
R.0021	Provide letters of financial support, credit, bond, or loan guarantee or other financial guarantees, if any, in at least the same amount that the obligations to Members will be performed.

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

Identifier	Operational Readiness Requirement
R.0022	Submit a Compliance Program, Standard of conduct or code of conduct, related policies and procedures, and training materials.
R.0023	Organizational chart for the Compliance Program showing key personnel.
R.0024	Submit a Fraud Prevention Program and related policies and procedures, training materials, and an organizational chart showing key personnel.
R.0025	Submit policies and procedures for the screening, Enrollment of Network Providers, if Contractor elects to screen and enroll.

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

Identifier	Operational Readiness Requirement
R.0026	Submit a completed MCO Baseline Assessment Form.

Identifier	Operational Readiness Requirement
R.0027	If procuring a new Management and Information System (MIS) or modifying a current system, Contractor must provide a detailed implementation plan that includes the following: 1) Outline of the tasks required; 2) The major milestones; and 3) The responsible party for all related tasks. In addition, the implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; and 4) Documentation of system changes related to Exhibit G, (*Business Associate Addendum*) requirements.
R.0028	Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data, Network Provider Data, Program Data, Template Data, and all other data required by this Contract from origination at the Provider level to Contractor, through submission to DHCS as well as how Contractor will transmit information regarding general and specific data quality issues identified by DHCS from origination to Providers for correction.
R.0029	Submit Encounter Data, Provider data, Program Data, and Template Data test files as required by DHCS, produced using real or proxy data processed by a new or modified MIS to DHCS. Production data submissions from a new or modified MIS may not take place until this test has been successfully reviewed and approved by DHCS.
R.0030	Submit policies and procedures for the submission of complete, accurate, reasonable and timely Encounter Data, Provider data, Program Data, Template Data, and all other data required by this Contract, including how Contractor will correct data quality issues identified by DHCS.
R.0032	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
R.0033	Submit a detailed description, including details regarding interoperability, of the proposed and/or existing MIS as it relates to each of the subsystems described in Exhibit A, Attachment III, Section 2.1 (*Management Information System*).

Identifier	Operational Readiness Requirement
R.0246	Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the Application Programming Interfaces (APIs) are functioning properly and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

Identifier	Operational Readiness Requirement
R.0035	Submit a flow chart and/or organization chart identifying all components of the Quality Improvement and Health Equity Transformation Program (QIHETP) including who is involved and responsible for each activity.
R.0036	Submit a flow chart and/or organization chart identifying all components of the QIHETP including who is involved and responsible for each activity, for each Fully Delegated Subcontractor, and each health plan downstream Subcontractor.
R.0037	Submit policies that specify the responsibility of the Governing Board in the QIHETP.
R.0038	Submit policies for the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities and reporting relationships to other committees within the organization.
R.0039	Submit policies for each Fully Delegated Subcontractor's and health plan Downstream Subcontractor's QIHEC including membership, activities, roles and responsibilities, and reporting relationships to other committees within the organization.
R.0040	Submit procedures outlining how Providers, health plan Subcontractors, and health plan Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how the findings from both will be shared with Providers, health plan Subcontractors and health plan Downstream Subcontractors.
R.0041	Submit policies and procedures related to the oversight of Subcontractors and Downstream Subcontractors for any delegated QIHETP activities, including a complete list of all Subcontractors, Downstream Subcontractors, and their delegated QIHETP activities.
R.0042	Submit policies and procedures that describe how Contractor will develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all Quality Improvement (QI) and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or Health Equity activities.

Identifier	Operational Readiness Requirement
R.0043	Submit policies and procedures to address how Contractor will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements; 2) **Meet or** exceed DHCS established Quality and Health Equity Performance measure benchmarks; 3) Ensure all Fully Delegated Subcontractors **meet or** exceed DHCS established Quality and Health Equity Performance measure benchmarks; 4) Performance Improvement Projects; 5) Consumer Satisfaction Survey; 6) Network Adequacy Validation; 7) Encounter Data Validation; 8) Focused Studies; and 9) Technical Assistance Recommendations.
R.0044	Submit policies and procedures for reporting any disease or condition to public health authorities.
R.0045	Submit policies and procedures for Credentialing and recredentialing that ensure all Network Providers who deliver Covered Services to Members are qualified in accordance with applicable standards and are licensed, certified, or registered, as appropriate.
R.0046	No later than January 1, 2024, submit either (A) or (B and C): A. Evidence of National Committee for Quality Assurance (NCQA) Health Plan Accreditation. B. Timeline that demonstrates the NCQA Health Plan Accreditation process will be started no later than January 1, 2024, and full NCQA Health Plan Accreditation will be received no later than January 1, 2026. C. Evidence of interim NCQA Health Plan Accreditation approval within five Working Days of receipt.
R.0047	No later than January 1, 2024, submit either (A) or (B): A. Evidence of NCQA Health Equity Accreditation. B. Timeline that demonstrates the NCQA Health Equity Accreditation process will be started no later than January 1, 2024 and completed no later than January 1, 2026.
R.0048	Submit policies and procedures for identifying, evaluating, and reducing Health Disparities.
R.0049	Submit policies and procedures that describe how Contractor ensures the adoption, dissemination and monitoring of the use of clinical practice guidelines.
R.0050	Submit policies and procedures that describe the integration of Utilization Management into the QIHETP.

Identifier	Operational Readiness Requirement
R.0051	Submit policies and procedures that describe how Contractor will detect both over- and under-utilization of services, including outpatient Prescription Drugs.
R.0052	Submit policies and procedures that describe how Contractor will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services provided for Members less than 21 years of age, and how Contractor will identify and address underutilization of preventive services for such Members.
R.0053	Submit policies and procedures that describe how Contractor will promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and preventive services to Members less than 21 years of age, as well as outreach to Members less than 21 years of age overdue for such services.
~~R.0054~~	~~Submit policies and procedures that describe how Contractor will ensure that Members less than 21 years of age are fully addressed in the Population Health Management Strategy, including Basic Population Health Management (Basic PHM), EPSDT, Case Management Services, Early Intervention and a Wellness and Prevention Program.~~
R.0055	Submit a description of a comprehensive wellness program for Members less than 21 years of age.
R.0056	Submit policies and procedures that describe how Contractor will maintain and continually monitor, evaluate, and improve Cultural and Linguistic (C&L) services that support the delivery of Covered Services to Members less than 21 years of age.
R.0057	Submit policies and procedures that describe how Contractor will develop and maintain a school-linked statewide Network of School Site Behavioral Health counselors.
R.0058	Submit policies and procedures that describe how Contractor will inform its Network Providers about the Vaccines for Children (VFC) program and how they will promote and support Enrollment of appropriate Providers in VFC.
R.0059	Submit policies and procedures that describe Contractor's Member and family engagement strategy and how Members and/or parents and caregivers are engaged in the development of QI and Health Equity activities and interventions.
R.0060	Submit policies and procedures that describe how Contractor will engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
R.0061	Submit policies and procedures that describe how Contractor will ensure the provision of all Medically Necessary mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

Identifier	Operational Readiness Requirement
R.0062	Submit written description of Utilization Management (UM) program that describes appropriate processes to be used to review, approve, modify, deny, and delay the provision of medical, mental health, and SUD services to demonstrate compliance with mental health parity.
R.0063	Submit written description of procedures for reviews and annual updates of UM program.
R.0064	Submit written description of Grievances and Appeals procedures for Providers and Members that will be published on Contractor's website.
R.0065	Submit policies and procedures for Standing Referrals.
R.0066	Submit policies and procedures on Standing Referrals when a Member condition requires a specialized medical care over a prolonged period of time.
R.0067	Submit policies and procedures for Prior Authorization, concurrent review, and Retrospective Review.
R.0068	Submit a list of services requiring Prior Authorization and the Utilization Review criteria.
R.0069	Submit policies and procedures for the Utilization Review Appeals process for Providers and Members.
R.0070	Submit policies and procedures that specify timeframes for medical authorization.
R.0072	Submit policies and procedures to detect both under- and over-utilization of health care services.
R.0073	Submit policies and procedures showing how UM functions which may be delegated to a Subcontractor or Downstream Subcontractor will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
R.0074	Submit policies and procedures to refer Members who are potentially eligible for Multipurpose Senior Service Program (MSSP) services to MSSP services Providers for authorization.

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

Identifier	Operational Readiness Requirement
R.0075	Submit policies and procedures for a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors.
R.0076	Submit executed Network Provider Agreements/Subcontractor Agreements/Downstream Subcontractor Agreements or documentation substantiating Contractor's efforts to enter into these agreements with the Local Health Department (LHD) for each of the following public health services: 1) Family Planning Services; 2) Sexually Transmitted Disease (STD) Services; 3) Human Immunodeficiency Virus (HIV) testing and counseling; and 4) Immunizations.
R.0244	Submit all Network Provider, Subcontractor, and Downstream Subcontractor Agreements templates.
R.0245	Submit Subcontractor and Downstream Subcontractor Agreement templates language showing accountability of any delegated QIHETP functions and responsibilities.

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

Identifier	Operational Readiness Requirement
R.0077	Submit policies and procedures for the Provider Dispute Resolution Mechanism.
R.0078	Submit a written description of how Contractor will communicate the Provider Dispute Resolution Mechanism to Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors.
R.0079	Submit protocols for payment and communication with out-of-Network Providers.
R.0080	Submit policies and procedures for ensuring out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
R.0081	Submit copy of Contractor's Provider manual.
R.0082	Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.

Identifier	Operational Readiness Requirement
R.0083	Submit policies and procedures for ensuring Network Providers receive training within the required timeframes, regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Senior and Person with Disability (SPD) Members.
R.0084	Submit protocols for communicating and interacting with emergency departments in and out of Contractor's Service Area.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

Identifier	Operational Readiness Requirement
R.0085	Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers (PCP) or clinics.
R.0086	Submit description of any Provider financial incentive programs including, but not limited to, Physician incentive plans as defined in 42 CFR section 422.208.
R.0087	Submit description of efforts to promote value-based models and investments in Primary Care using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) Framework as outlined in the Alternative Payment Model (APM) Framework White Paper, https://hcp-lan.org/workproducts/apm-whitepaper.pdf.
R.0088	Submit policies and procedures for processing and payment of claims.
R.0089	Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.
R.0090	Submit any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements to DHCS for approval.
R.0091	Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs).
R.0092	Submit policies and procedures for the reimbursement of Skilled Nursing Facilities and Nursing Facilities (SNF/NF).
R.0093	Submit policies and procedures for the reimbursement to LHDs and non-contracting family planning Providers for the provision of family planning services, STD episode, and HIV testing and counseling.
R.0094	Submit policies and procedures for the reimbursement of immunization services to LHD.

Identifier	Operational Readiness Requirement
R.0095	Submit policies and procedures regarding payment to non-contracting Emergency Services Providers. Include reimbursement schedules for all non-contracting Emergency Service Providers, including any schedule of per diem rates and/or Fee-for-Service (FFS) Rates for each of the following Provider types: 1) PCPs; 2) Medical Groups and Independent Practice Associations; 3) Specialists; and 4) Hospitals.
R.0096	Submit policies and procedures for reporting Provider-Preventable Conditions.
R.0247	Submit policies and procedures for pre-payment and post-payment claims review.

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

Identifier	Operational Readiness Requirement
R.0097	Submit policies and procedures for training and certification of Marketing Representatives.
R.0098	Submit a description of training program, including the Marketing Representative's training/certification manual.
R.0099	Submit Contractor's Marketing plan.
R.0100	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a Marketing event.

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

Identifier	Operational Readiness Requirement
R.0101	Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
R.0102	Submit policies and procedures for how Contractor will access and utilize Enrollment data from DHCS.
R.0103	Submit policies and procedures relating to Member disenrollment.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

Identifier	Operational Readiness Requirement
R.0108	Submit evidence illustrating Contractor's MIS has the capacity to meet DHCS data integration and exchange requirements as outlined in Exhibit A, Attachment III, Subsection 4.3.3 (*Data Integration and Exchange*).

Identifier	Operational Readiness Requirement
R.0110	Submit policies and procedures for complying with the Risk Stratification/Segmentation (RSS) requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*).
R.0111	Submit Contractor's process(es) describing how Contractor identifies Significant Changes in Members' health status or level of care and how Contractor monitors to ensure appropriate re-stratification.
R.0112	Submit a list of the data used by Contractor's RSS approach that includes the required sources in Exhibit A, Attachment III, Subsection 4.3.5.A.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*) at a minimum. For each type of data listed, Contractor must include a description of the data and its origin, and how the data will be incorporated into the RSS approach.
R.0113	Submit a description of Contractor's population RSS and Risk Tiering approach, as well as the processes for how RSS and Risk Tiers are used to connect Members to appropriate services.
R.0114	Submit the method of bias analysis used to analyze Contractor's RSS and Risk Tiering approach, and the analysis of whether any biases were identified and if so, how they were corrected.
R.0115	Submit policies and procedures for conducting an initial screening or assessment of each Member's needs within 90 days of Enrollment, for sharing that information with DHCS, other Contractors, or Providers on behalf of Members, as appropriate, and for monitoring the completion of the assessments.
R.0116	Submit a description of Contractor's Complex Care Management (CCM) program outlining the types of Members, populations and/or program criteria established, the CCM program's approach for both long-term chronic conditions and episodic, temporary interventions, and processes for fulfilling all the other CCM program requirements outlined in Exhibit A, Attachment III, Subsection 4.3.7.A.2 (*Care Management Programs*).
R.0117	Submit policies and procedures for handling care management, and the non-duplication of services when multiple Subcontractors, Downstream Subcontractors, and/or Providers are involved in a Member's care.
R.0118	Submit policies and procedures for assigning Care Managers to Members, and monitoring to ensure all Care Managers' responsibilities are fulfilled.
R.0119	Submit policies and procedures for documenting and maintaining Care Management Plans (CMPs).

Identifier	Operational Readiness Requirement
R.0120	Submit policies and procedures that meet the Basic PHM requirements outlined in Exhibit A, Attachment III, Subsection 4.3.8.A (*Basic Population Health Management*). Contractor's policies and procedures should address core Basic PHM, Care Coordination, care navigation and referral needs of all Members. Contractor's policies and procedures must also address requirements regarding wellness and prevention programs and chronic disease management programs.
R.0121	Submit evidence that Contractor is providing the Provider resources as required by Exhibit A, Attachment III, Subsection 4.3.8.B (*Basic Population Health Management*).
R.0122	Submit policies and procedures for identifying, referring, and providing EPSDT case management services for Members less than 21 years of age.
R.0123	Submit policies and procedures for identifying and providing care management services for Children with Special Health Care Needs (CSHCN).
R.0124	Submit policies and procedures for identifying, referring, and providing care management services for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.
R.0125	Submit policies and procedures for the provision of comprehensive wellness and prevention programs to all Members.
R.0126	Submit policies and procedures for providing Transitional Care Services as outlined in Exhibit A, Attachment III, Subsection 4.3.11.A (*Targeted Case Management Services*).
R.0127	Submit Contractor's standardized discharge risk assessment that identifies Members' risk for re-hospitalization, re-institutionalization, and substance use recidivism.
R.0128	Submit Contractor's strategy for developing policies and procedures for Discharge Planning and Transitional Care Services with each Network and out-of-Network Provider hospital within its Service Area(s).
R.0129	Submit policies and procedures for ensuring Discharge Planning documents are completed, and that the documents fulfill the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.11.B (*Targeted Case Management Services*), and are provided to Members, parents, legal guardians, or Authorized Representatives (AR) when being discharged from a hospital, institution, or facility.
R.0131	Submit policies and procedures for coordinating care for Members who may need or are receiving services and/or programs from out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0132	Submit policies and procedures for identifying and referring the target populations for Targeted Case Management (TCM) programs within Contractor's Service Area(s) and for reaching out to Local Government Agencies (LGAs) to coordinate care, as appropriate, upon notification from DHCS that Members are receiving TCM services. Policies and procedures must include processes for ensuring non-duplicative services.
R.0133	Submit policies and procedures for identifying, referring, and coordinating care for Members in need of Non-specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS) and/or SUD treatment services with Contractor's Network, the County Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal, or other community resources. Contractor is required to use the State-approved screening and transition tools.
R.0134	Submit policies and procedures for identifying, referring, and coordinating care for Members requiring alcohol or SUD treatment services from both within and, if necessary, outside Contractor's Service Area(s) in partnership with the LGAs responsible for such services.
R.0135	Submit policies and procedures for identifying, referring, and coordinating care for Members with the local California Children's Services (CCS) Program.
R.0136	Submit policies and procedures for the identifying, referring, and coordinating care for Members with Developmental Disabilities (DD) in need of non-medical services from the local Regional Center (RC) that includes the duties of the RC liaison.
R.0137	Submit policies and procedures for ensuring Care Coordination of Local Education Agency (LEA) services, including PCP involvement in the development of the Member's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).
R.0138	Submit policies and procedures for identifying, referring, and ensuring Care Coordination and non-duplication of services for Members who are eligible for or who are already receiving contracted school-based services, such as EPSDT and Behavioral Health Services, from either LEAs, FQHCs or community-based organizations.
R.0139	Submit policies and procedures for providing required dental services and dental-related services that includes the duties of Contractor's dental liaison.
R.0140	Submit policies and procedures for ensuring case management and Care Coordination of Members with the LHD Tuberculosis (TB) Control Officer. Policies and procedures must include assessing and referring Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

Identifier	Operational Readiness Requirement
R.0141	Submit policies and procedures for identifying and referring eligible Members for Women, Infants and Children Supplemental Nutrition Program (WIC) services.
R.0142	Submit policies and procedures for identifying and referring eligible Members to Home and Community-Based Services (HCBS) programs. Policies and procedures must include processes for ensuring non-duplicative services.
R.0143	Submit policies and procedures for identifying and referring eligible Members to the county In-Home Supportive Services (IHSS) program, the duties of Contractor's IHSS liaison. and ensure compliance with the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Supportive Services*).
R.0144	Submit policies and procedures that described the duties and responsibilities of Contractor's Indian Health Care Provider (IHCP) tribal liaison in working with IHCPs within Contractor's Service Area(s).
R.0248	Submit policies and procedures that describe the duties and responsibilities of Contractor's managed care liaisons, including training and notification requirements for each of the following required liaisons: 1) Long-Term Services and Supports (LTSS) Liaison; 2) Transportation Liaison; 3) CCS Liaison; and 4) ~~Foster Care~~ **County Child Welfare** Liaison.

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

Identifier	Operational Readiness Requirement
R.0145	Submit an Enhanced Care Management (ECM) Model of Care (MOC) using the DHCS approved template. If Contractor has a previously approved MOC for implementation of ECM effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.4.5.D (*Enhanced Care Management Model of Care*) and in accordance with DHCS policies and guidance, including All Plan Letters (APLs). Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements and Downstream Subcontractor Agreements boilerplates.

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

Identifier	Operational Readiness Requirement
R.0146	Submit a Community Supports MOC using the DHCS approved template. If Contractor has a previously approved MOC for implementation of Community Supports effective January 1, 2022 or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.5.5.D (*Community Supports Model of Care*) and in accordance with DHCS policies and guidance, and APLs. Substantial changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreements, or Downstream Subcontractor Agreements boilerplates, as appropriate.

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

Identifier	Operational Readiness Requirement
R.0147	Submit policies and procedures relating to Contractor's Member Grievance and Appeal system including compiling, aggregating, and reviewing Grievance and Appeal data.
R.0148	Submit policies and procedures for Contractor's oversight of the Member Grievance and Appeal system for the receipt, processing and distribution of Grievance and Appeals, including the expedited review of Appeals. Include a flow chart to demonstrate the process.
R.0149	Submit policies and procedures relating to Contractor's Grievances and the expedited review of Grievances as required by 42 CFR sections 438.402, 438.406, and 438.408, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858.
R.0150	Submit policies and procedures relating to the resolution of Discrimination Grievances.
R.0151	Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in State Hearings, Independent Medical Review, and expedited Appeals.
R.0152	Submit format for monthly Grievance and Appeal report.

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

Identifier	Operational Readiness Requirement
R.0153	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.
R.0154	Submit policies and procedures for training Contractor's Member Services staff on Member rights, responsibilities, and services available under this Contract.
R.0155	Submit policies and procedures for training Contractor's Network Providers, Subcontractors, and Downstream Subcontractors on Member rights, Covered Services, and other responsibilities.
R.0156	Submit policies and procedures for handling Member Grievances not related to an Adverse Benefit Determination (ABD).
R.0157	Submit policies and procedures for providing communication access to Members in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or written translations and oral interpreters, including Limited English Proficiency (LEP) Members, or non-English speaking.
R.0158	Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990 (42 United States Code (USC) section 12101 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC section 794), Section 1557 of the Patient Protection and Affordable Care Act (42 USC section 18116), SB 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018), and Government Code(GC) section 11135, as required in APL 21-011.
R.0159	Submit the following consistent with the requirements of Exhibit E, Section 1.23 (*Confidentiality of Information*). Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information and the right to amend or correct Medical Records pursuant to 45 CFR sections 164.524 and 164.526.
R.0160	Submit policies and procedures for addressing Advance Directives.
R.0161	Submit policies and procedures for the training of Member services staff.
R.0162	Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.
R.0163	Submit final approved Member Identification Card and Member Handbook.
R.0164	For non-COHS Contractors, submit policies and procedures explaining the Member's right to an Independent Medical Review (IMR) including when an expedited IMR is available to the Member.

Identifier	Operational Readiness Requirement
R.0165	Submit policies and procedures explaining the Member's right to a State Hearing after receiving a Notice of Appeal Resolution or in cases of Deemed Exhaustion. These policies and procedures must also include the information on the Member's right to an expedited State Hearing if his/her health condition is in jeopardy.
R.0166	Submit policies and procedures and live notice Contractor will send to Members advising them of how to obtain Member informing materials including the Member Handbook, and Provider Directory.
R.0167	Submit policies and procedures on the Member's right to disenroll at any time to enroll in another Medi-Cal Managed Care Plan pursuant to 22 CCR section 53891(c).
R.0168	Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.
R.0169	Submit policies and procedures for Member selection of a PCP or non-physician medical practitioner. Include the mechanism used for allowing SPD Members to request a Specialist to serve as their PCP.
R.0170	Submit policies and procedures for Member Assignment to a PCP. Include the use of FFS utilization data and other data in linking a SPD to a PCP, or Specialist acting as the SPD's PCP.
R.0171	Submit policies and procedures for notifying the PCP that a Member has selected or has been assigned to within ten calendar days from the selection or assignment.
R.0172	Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and the Member is not disrupted, to the maximum extent possible.
R.0173	Submit policies and procedures for notifying Members of an ABD for denial, deferral, or modification of requests for Prior Authorization, including explanation of Deemed Exhaustion to the Member.
R.0249	Submit policies and procedures to demonstrate how, for dates of service on or after January 1, 2016, Contractor will make the data it maintains available within one Working Day of receipt data or information, or one Working Day after a claim is adjudicated or Encounter Data is received.
R.0250	Submit policies and procedures to demonstrate how Contractor will update its Provider Directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the Provider Directory.

Identifier	Operational Readiness Requirement
R.0251	Submit ~~website mock-ups showing where a third-party applicant can easily access Contractor's patient access and Provider Directory APIs~~ **a hard copy of the patient access API and Provider Directory API documentation and the publicly accessible link or web URL where each API is located. The documentation must be accessible without any preconditions to access, and contents must include at a minimum the following information:** **1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;** **2) The software components and configurations an application shall use to successfully interact with the API and process its response(s); and** **3) All applicable technical requirements and attributes necessary for an application's registration with any authorized server(s) deployed in conjunction with the API**.
R.0252	Submit a **hard copy and a** link to Contractor's publicly accessible Member educational resources that will achieve the following: 1) Demonstrate the steps Member may consider taking to help protect the privacy and security of their health information and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and 2) Provide an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to OCR and FTC.

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

Identifier	Operational Readiness Requirement
R.0174	Submit policies and procedures on how Contractor will assist Members in selecting PCPs who are accepting new patients and how it will afford access to Primary Care and specialty care.
R.0175	Submit complete 274 Provider File demonstrating the ability to serve 60 percent of Potential Members, including SPD Members, in each of the counties that Contractor serves pursuant to this Contract.
R.0176	Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement Network and/or out-of-Network FQHC, RHC, Freestanding Birthing Center (FBC) services, CNMs, and Licensed Midwives (LMs).

Identifier	Operational Readiness Requirement
R.0177	Submit policies and procedures that establish traditional and Safety-Net Provider participation standards.
R.0178	Submit policies and procedures describing how Contractor will monitor Provider to Member ratios to ensure they are within specified standards.
R.0179	Submit policies and procedures regarding Physician supervision of non-physician medical practitioners.
R.0180	Submit policies and procedures to monitor and ensure how Contractor, Network Providers, Subcontractors and Downstream Subcontractors comply with timely access requirements for each of the following: 1) Standards for timely appointments; 2) Appropriate clinical timeframes; 3) Shortening or expanding timeframes; 4) Follow up appointments; 5) Triaging Member calls; 6) Telephone interpreters; and 7) Contractor's customer service line.
R.0181	Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS recipients.
R.0182	Submit a policy regarding the availability of Contractor's Medi-Cal director or licensed Physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.
R.0183	Submit all documents outlined for the Network Certification demonstrating that the proposed Network meets the appropriate Network adequacy standards set forth in this Contract and Welfare and Institutions Code (W&I) section 14197. See APL 23-001 for document specification and submission guidelines. Network certification must be submitted in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e).
R.0184	Submit policies and procedures for providing Emergency Services including 24-hr. /day access without Prior Authorization, follow-up and coordination of emergency care services.
R.0185	Submit policies and procedures for authorizing and arranging for out-of-Network access, including arranging transportation services for Members to access the out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0186	Submit policies and procedures for the provision of and access to each of the following: 1) Family planning services; 2) STD services; 3) HIV testing and counseling services; 4) COVID therapeutics (see APL 22-009); 5) Pregnancy termination; 6) Minor Consent Services; 7) Immunizations; 8) IHCP services; 9) CNM and NP services; 10) NSMHS for minors; and 11) Medication for Addiction Treatment (MAT).
R.0187	Submit policies and procedures for the timely referral and coordination of Covered Services to which Contractor, Subcontractor, or Downstream Subcontractor has moral objections to perform or otherwise support.
R.0188	Submit policies and procedures for the provision of 24 hour interpreter services at key points of contact.
R.0189	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with State and federal language and communication assistance requirements.
R.0190	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with civil rights laws requiring access for Members with disabilities.
R.0191	Submit a written description of the C&L services program and policies and procedures for monitoring and evaluation of the C&L services program.
R.0192	Submit an analysis demonstrating the ability of Contractor's Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.
R.0193	Submit policies and procedures for providing cultural competency/humility, sensitivity or diversity training for staff, Network Providers, Subcontractors, and Downstream Subcontractors at key points of contact.
R.0194	Submit policies and procedures describing Contractor's Member and family engagement strategy and how Contractor will ensure Member and/or parent and caregiver input into appropriate policies and decision-making.

Identifier	Operational Readiness Requirement
R.0195	Submit policies and procedures describing how Contractor will ensure the following with regards to the Community Advisory Committee (CAC): 1) How Contractor will ensure a diverse membership on the CAC that is reflective of Contractor's Service Area~~(s)~~ and includes adolescents and/or parents/caregivers of Members less than 21 years of age; 2) How Contractor will support Member participation in the CAC; 3) How Contractor will ensure the CAC will be involved in appropriate policies and decision-making; 4) How Contractor will actively facilitate communication and connection between the CAC and Contractor leadership; and 5) How Contractor will ensure that one Member of the CAC participates in the DHCS Statewide CAC and how Contractor will support Member's attendance and participation in that Committee.
R.0196	Submit policies and procedures for providing continuity of care including the completion of Covered Services by Providers and out-of-Network Providers.
R.0197	Submit policies and procedures for performance of Facility Site Reviews (FSR) and Medical Record reviews (FSR Attachments A and B), and performance of Facility Site physical accessibility reviews (FSR Attachment C).
R.0198	Submit the aggregate results of pre-operational Site Reviews to DHCS at the request of DHCS. The aggregate results must include all data elements specified by DHCS.

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

Identifier	Operational Readiness Requirement
R.0199	Submit policies and procedures, including standards, for the provision of each of the following services for Members less than 21 years of age: 1) Children's preventive services; 2) Immunizations; 3) Blood Lead screens; and 4) EPSDT services.
R.0200	Submit policies and procedures for the provision of adult preventive services, including immunizations.
R.0201	Submit policies and procedures for the provision of each of the following services to pregnant Members: 1) Prenatal and postpartum care; 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant Members; and 4) Referral to Specialists.

Identifier	Operational Readiness Requirement
R.0202	Submit a list of appropriate hospitals available within the Network that provide necessary high-risk pregnancy services.
R.0203	Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration, and oversight.
R.0204	Provide a list and schedule of all health education classes and/or programs.
R.0205	Submit policies and procedures for the provision of Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).
R.0206	Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
R.0208	Submit policies and procedures for the provision of Major Organ Transplants as Covered Services.
R.0209	Submit policies and procedures for the provision of Long-Term Care (LTC) as Covered Services.
R.0210	Submit policies and procedures for the provision of services at non-contracted LTC facilities.
R.0211	Submit policies and procedures for conducting a Drug Use Review (DUR).
R.0212	Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR section 438.900 *et seq.*
R.0213	**Submit policies and procedures for the coverage of clinical trials and routine patient care costs.**

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

Identifier	Operational Readiness Requirement
R.0215	Submit policies and procedures for referring a Member to a Community Based Adult Services (CBAS) Provider.
R.0216	Submit policies and procedures on arranging for the provision of CBAS unbundled services.
R.0217	Submit all policies and procedures required by the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, Section V.A.23.
R.0218	Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
R.0219	Submit policies and procedures for an expedited assessment process.

Identifier	Operational Readiness Requirement
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Identifier	Operational Readiness Requirement
R.0207	Submit policies and procedures for when a Member becomes eligible for SMHS and/or SUD treatment services during the course of receiving NSMHS, including how Contractor will use required State-approved transition of care tool for coordinating care between Contractor and MHPs.
R.0213	Submit policies and procedures for handling of psychiatric emergencies during non-business hours.
R.0214	Submit policies and procedures for verifying the credentials of licensed mental health Providers of NSMHS.
R.0222	Submit policies and procedures for entering into agreements with MHPs, Non-specialty Mental Health Services Providers, county DMC-ODS plans, counties administering California Medicaid State Plan benefits, and SUD treatment Providers in order to comply with access standards and Care Coordination requirements, including those concerning the concurrent provision of covered NSMHS and SMHS consistent with WI section 14184.402(f)(1).
R.0223	Submit policies and procedures for the provision of SUD services including drug and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) services, including: 1) Provision of SBIRT by a Member's PCP to identify, reduce, and prevent problematic substance use; 2) Referral, without requiring Prior Authorization, for SBIRT services for Members whose PCPs do not offer SBIRT services; and 3) Referral of Members to SUD treatment without requiring Prior Authorization, when there is a need beyond SBIRT services.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

Identifier	Operational Readiness Requirement
R.0224	Submit executed MOUs, or documentation substantiating Contractor’s efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities and county programs in Contractor’s Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including, but not limited to: 1) LHDs in each County within Contractor’s Services Area for the following programs and services: a) CCS; b) Maternal and Child Health (MCH); c) TB Direct Observed Therapy (DOT); and d) Community Health Workers (CHW). 2) WIC agencies in each county within Contractors' Service Area. 3) LGAs such as the County Behavioral Health Department and County Social Services Department, in each county within Contractors' Service Area to assist with coordinating the following programs and services: a) SMHS; b) Alcohol and SUD treatment services, including counties administering State plan Drug Medi-Cal benefits and counties participating in DMC-ODS;**and** ~~c) TCM; and~~ ~~d~~**c**)IHSS. 4) LGAs to coordinate programs and services for Members in each county within Contractors Service Area at a minimum: a) Social Services; and b) Child welfare departments. 5) RCs for persons with DDs.

Identifier	Operational Readiness Requirement
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) LEAs for IEPs or IFSPs; 2) **California Department of Corrections and Rehabilitation, County** Jails, ~~juvenile~~ **and youth correctional** facilities, **as applicable** ~~and probation departments~~; and 3) Third-party entities in each county within Contractor's Service Area, at a minimum: a) HCBS program agencies; b) Continuums of Care; c) First 5 programs; d) Area Agencies on Aging (AAA); and e) Caregiver Resource Center (CRC).
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.
R.0228	**Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).**

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

No deliverables listed for this Article. (To Become Effective on January 1, 2025)

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

Identifier	Operational Readiness Requirement
R.0233	Submit documentation of the Coordination of Benefits Agreement (COBA) that Contractor has entered into with Medicare.

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0241	Submit updated report on any conflicts of interest and/or conflict avoidance plan, if requested by DHCS.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0242	Submit parent guaranty, if applicable.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

Identifier	Operational Readiness Requirement
R.0243	Submit delegation reporting and compliance plan (Template A, B, and C).

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit A, ATTACHMENT III

1.0 Organization

The Department of Health Care Services (DHCS) seeks to ensure that only those managed care plans that have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and State requirements and standards under this Contract, may be Contractors.

Article 1.0 outlines DHCS' requirements for plan organization and administration including key leadership roles, including the designation of a Chief Health Equity Officer having the authority to design and implement policies that ensure Health Equity is prioritized and addressed. Key personnel changes, including those relevant to Contractor, Subcontractors, and Downstream Subcontractors, must be reported to DHCS in a timely fashion. The financial health and well-being of Contractors are vital to ensuring access to Medi-Cal Covered Services, and, as such DHCS, requires reporting of financial data for review. In addition, DHCS will ensure minimum loss ratios are in place for Contractors, Subcontractors, and Downstream Subcontractors who take financial risk to provide services for Members. Additionally, requiring that a portion of profits invested back into the community, will help ensure that Contractors are seeking opportunities to work at a local level to further efforts to address Social Drivers of Health (SDOH) and drive improvements in quality, equity, and access to care.

Article 1.0 also outlines requirements for Contractors to ensure that they have a clear compliance plan to meet the requisite personnel, processes, and capacity as outlined in the Contract.

1.1 Plan Organization and Administration

1.1.1 Legal Capacity
1.1.2 Key Personnel Disclosure Form
1.1.3 Conflict of Interest – Current and Former State Employees
1.1.4 Contract Performance
1.1.5 Medical Decisions
1.1.6 Medical Director
1.1.7 Chief Health Equity Officer
1.1.8 Key Personnel Changes
1.1.9 Administrative Duties/Responsibilities
1.1.10 Member Representation
1.1.11 Diversity, Equity, and Inclusion Training

Exhibit A, ATTACHMENT III

1.1 Plan Organization and Administration

1.1.1 Legal Capacity

Contractor must maintain the legal capacity to contract with Department of Health Care Services (DHCS) and, if required, maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (KKA) as amended (Health and Safety Code (H&S) section 1340 *et seq.*). If Contractor is not currently licensed to operate in an awarded Service Area, within 30 Working Days of award of Contract, it must submit a material modification to its license to the Department of Managed Health Care (DMHC) requesting authorization to operate in the Service Area. Contractor must submit proof of its material modification submission to DHCS concurrently. Operations Period will not begin until the material modification is approved by DMHC. Within three Working Days of approval, Contractor must submit a copy of its approved and amended Knox-Keene license to DHCS.

1.1.2 Key Personnel Disclosure Form

A. Contractor must file an annual statement with DHCS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1) Any person or corporation having five percent or more ownership or controlling interest in Contractor;

2) Any director, officer, partner, trustee, or employee of Contractor; and

3) Any member of the immediate family of any person designated in 1) or 2) above.

B. Comply with 42 Code of Federal Regulations (CFR) sections 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 438.610 (Prohibited affiliations).

1.1.3 Conflict of Interest – Current and Former State Employees

A. This Contract will be governed by the conflict of interest provisions of 42 CFR sections 438.3(f)(2) and 438.58 and 22 California Code of Regulations (CCR) sections 53874 and 53600.

B. In the performance of this Contract, Contractor will not utilize any State officer, employee in State civil service, other appointed State official, or intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

1.1.4 Contract Performance

Contractor must maintain the necessary organization and level of staffing to implement and operate this Contract in accordance with 28 CCR section 1300.67.3 and 22 CCR sections 53800, 53851, and 53857. Contractor must ensure the following:

A. Contractor has an accountable Governing Board;

B. Compliance with this Contract is a high priority and that Contractor is committed to supplying any necessary resources to assure full performance of the Contract;

C. If Contractor is a subsidiary organization, its parent organization provides an attestation confirming that this Contract will be a high priority to the parent organization and committing to supply any necessary resources to assure full performance of the Contract;

D. Adequate staffing in medical and other health services, fiscal and administrative capacity sufficient to effectively conduct Contractor's business; and

E. Written procedures are developed and maintained for conducting Contractor's business, including the provision of health care services, in compliance with federal and State Medicaid law.

1.1.5 Medical Decisions

Contractor must ensure that medical decisions, including those by Subcontractors, Downstream Subcontractors, Network Providers, and other Providers, are not unduly influenced by fiscal and administrative management.

1.1.6 Medical Director

Contractor must appoint a physician as medical director pursuant to 22 CCR section 53857 whose responsibilities must include, but should not be limited to, the following:

A. Ensuring that medical and other health services decisions are:

1) Rendered by qualified medical personnel; and

2) Not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical and other health care provided meets acceptable standards of care;

C. Ensuring that Contractor's medical personnel follow medical protocols and rules of conduct;

D. Developing and implementing medical policy consistent with applicable standards of care;

E. Resolving Grievances related to Quality of Care;

F. Participating directly in the implementation of Quality Improvement and Health Equity activities;

G. Participating directly in the design and implementation of the Population Health Management Strategy and initiatives**, including Population Needs Assessment design, planning, and implementation to inform Strategy;**

H. Participating actively in the execution of Grievance and Appeal procedures;

I. Ensuring that Contractor engages with local health departments; and

J. Posting medical director contact information in an easily accessible location on their provider portal website.

1.1.7 Chief Health Equity Officer

Contractor must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to

meet the requirements of the position. The Chief Health Equity Officer responsibilities must include, but should not be limited to, the following:

A. Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed;

B. Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including but not limited to:

1) Marketing strategy;

2) Medical and other health services policies;

3) Member and provider outreach;

4) Community Advisory Committee;

5) Quality Improvement activities, including delivery system reforms;

6) Grievance and Appeals; and

7) Utilization Management.

C. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;

D. Engage and collaborate with Contractor staff, Subcontractors, Downstream Subcontractors, Network Providers, and entities including, but not limited to local community-based organizations, local health departments, Behavioral Health and social services, Child welfare systems and Members in Health Equity efforts and initiatives;

E. Implement strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers;

F. Develop targeted interventions designed to eliminate Health Inequities;

G. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities;

H. Ensure all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*) annually. This includes, but is not limited to:

1) Reviewing training materials to ensure the materials are up to date with current standards of practice; and

2) Maintaining records of training completion.

1.1.8 Key Personnel Changes

Contractor must report to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the chief medical director, the chief Health Equity officer, the compliance officer, and government relations persons within ten calendar days. Contractor must also report to DHCS Contract Manager any changes in the status of the executive-level personnel for Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief Health Equity officer, the compliance officer, and government relations persons within 20 calendar days.

1.1.9 Administrative Duties/Responsibilities

Contractor must maintain the organizational and administrative capabilities to carry out Contractor's duties and responsibilities under the Contract. At a minimum, Contractors' responsibilities must include the following:

A. Comply with all requirements and deliverables as described in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*);

B. Maintain financial records and books of account on an accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*);

C. Maintain a Member and Enrollment reporting systems as specified in Exhibit A, Attachment III, Section 2.1 (*Management Information System*),

Section 4.6 (*Member Grievance and Appeal System*), and Section 5.1 (*Member Services*);

D. Maintain data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment III, Section 2.1 (*Management Information System*);

E. Maintain data and information exchange capabilities as needed to meet Contractor's obligation under the Contract and to support DHCS administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, Encounter Data, Medical Record information, Network Provider and Provider information, Member demographics, and case notes;

F. Maintain Quality Improvement activities and Population Health Management activities. Comply with all National Committee for Quality Assurance (NCQA) and accreditation requirements by calendar year 2026 as described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*);

G. Maintain a Utilization Management (UM) program, as described in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

H. Maintain Network adequacy as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

I. Comply with requirements, as described in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*);

J. Maintain claims processing capabilities as described in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*);

K. Maintain adequate access and availability of Primary Care Providers (PCP) and Specialists for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

L. Form a Community Advisory Committee (CAC) and meet expectations, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*), including CAC's active participation in addressing Quality of Care, Health Equity, Health Disparities, Population Health Management, Children services, and other ongoing Contractor functions;

M. Provide or arrange for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Exhibit A, Attachment III, Section 5.4 (*Community Based Adult Services*), and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

N. Provide Care Coordination, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Network, as described in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*);

O. Negotiate in good faith and execute Network Provider Agreements, Subcontractor Agreements, or Memorandums of Understanding (MOUs), as appropriate, with third party entities, including county programs, and local health jurisdictions covered by this Contract, as described in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) and Exhibit A, Attachment III, Subsection 3.1.9 *(Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments)*;

P. Comply with the requirements described in Exhibit A, Attachment III, Section 5.1 (*Member Services*);

Q. Maintain Member Grievance procedures, as specified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

R. Develop training and certification for Marketing activity, if Contractor conducts Marketing, as described in Exhibit A, Attachment III, Section 4.1 (*Marketing*);

S. Cooperate with the DHCS Enrollment program, as described in Exhibit A, Attachment III, Section 4.2 (*Enrollments and Disenrollments*); and

T. Comply with all requirements and deliverables, as described in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

1.1.10 Member Representation

Contractor must ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public

policy within Contractor's advisory committee and CAC, as specified in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*), or other similar committees or groups.

1.1.11 Diversity, Equity, and Inclusion Training

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, receive annual sensitivity, diversity, communication skills, and cultural competency/humility training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*).

Exhibit A, ATTACHMENT III

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance
1.2.2 Contractor's Financial Reporting Obligations
1.2.3 Independent Financial Audit Reports
1.2.4 Cooperation with DHCS' Financial Audits
1.2.5 Medical Loss Ratio
1.2.6 Contractor's Obligations
1.2.7 Community Reinvestment Plan and Report

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance

Contractor must meet and maintain financial viability and standards compliance to DHCS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times must be in compliance with the TNE requirements set forth in 28 California Code of Regulations (CCR) section 1300.76, even in circumstances where Contractor is not otherwise legally required to comply with this provision.

B. Administrative Costs.

Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b) and 28 CCR section 1300.78.

C. Standards of organization and financial soundness.

Contractor must maintain an organizational structure sufficient to conduct the operations required by this Contract and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR sections 1300.67, 1300.67.3, 1300.75.1, 1300.75.4.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, and 1300.77.4.

D. Working Capital Ratio of one of the following:

1) Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4(b)(1)(A)(iv); or

2) Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor must provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent Working Capital Ratio of 1:1, if the noncurrent assets are considered current.

E. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this provision, DHCS may impose a

Corrective Action plan or sanctions in accordance with Exhibit E (*Program Terms and Conditions*) and Welfare and Institutions Code (W&I) section 14197.7, as set forth in in All Plan Letter (APL) 23-012. See Exhibit E, Section 1.19 (*Sanctions*).

1.2.2 Contractor's Financial Reporting Obligations

A. Form and Standards for Financial Reporting

Contractor must provide financial information and reports, including but not limited to Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 Health Maintenance Organization (HMO) Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) rules found under 28 CCR sections 1300.51 *et seq*.

Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:

1) Jurat;
2) Report 1A and 1B: Balance Sheet;
3) Report 2: Statement of Contract Revenue, Expenses, and Net Worth;
4) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;
5) Report 4: Enrollment and Utilization Table;
6) Schedule G: Unpaid Claims Analysis;
7) Appropriate footnote disclosures in accordance with GAAP; and

8) Schedule H: Aging of All Claims.

In addition, Contractor must prepare and submit a stand-alone Medi-Cal line of business income statement and Enrollment table on each financial reporting period required. Contractor must prepare this income statement and Enrollment table in the DMHC required financial reporting format for each specific county or rating region of operation, as specified by DHCS and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses; and

2) Report 4: Enrollment and Utilization Table by County/Rating Region.

Medi-Cal line of business Financial Statements are to include expenses, Contract Revenues, and Enrollment only for Medi-Cal Members enrolled through direct contract with DHCS.

Contactor must submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

B. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than 30 calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

C. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than 45 calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

D. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than 120 calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06. Contractor must also submit Medi-Cal line of business Financial Statements no later than 120 calendar days of after the close of the applicable Rating Period.

E. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than 60 calendar days prior to the beginning each Fiscal Year. Contractor's annual forecast must be prepared using DMHC required financial reporting forms and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);

2) Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);

3) TNE (All lines of business); and

4) A detailed explanation of all underlying assumptions used to develop the forecast.

F. Publication of Financial Reports

Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.

1.2.3 Independent Financial Audit Reports

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 Code of Federal Regulations (CFR) section 438.3(m) and W&I section 14459. Except as indicated in Paragraph B of this provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined, annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined, annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S section 1382 within 30 calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined, annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

A. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

B. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within 180 calendar days after the close of Contractor's Fiscal Year in accordance with H&S section 1384;

C. Contractor must authorize its independent Certified Public Accountant to allow DHCS' designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report;

D. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and

E. Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten calendar days of submission to such other public or private organization.

1.2.4 Cooperation with DHCS' Financial Audits

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose. Please see Exhibit A, Attachment III, Section 2.1 (*Management Information System*) for related requirements.

1.2.5 Medical Loss Ratio

Contractor must annually report a Medical Loss Ratio (MLR) as described in this provision and in accordance with 42 CFR section 438.8. ~~For Rating Periods during which the State mandates a minimum MLR remittance in accordance with 42 CFR section 438.8(j),~~ Contractor must impose equivalent MLR reporting requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors. ~~Starting January 1, 2025, Contractor must impose equivalent remittance requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.~~

A. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

1) Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing which amounts were actually paid for benefits~~,~~ or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities **in accordance with the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019, with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors."**

2) Contractor must, in compliance with 42 CFR section 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915(b) Waiver STCs, require all applicable Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMS Informational Bulletin published May 15, 2019 with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors." Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims.

B. The MLR experienced by Contractor in a MLR reporting year is the ratio of the numerator, as stated in Paragraph ~~C~~**E** of this Section, to the

denominator, as stated in Paragraph ~~D~~**F** of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph ~~F~~**H** of this provision.

C. DHCS utilizes a materiality threshold for determining whether Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors are subject to the reporting and remittance requirements. The materiality threshold may be based on one or more of the following:

1) Annual Medi-Cal revenue;

2) The Medi-Cal lives for which risk is delegated;

3) The scope of Medi-Cal services for which risk is delegated; or

4) Other factors.

D. Subcontractor and Downstream Subcontractor arrangements that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right to reestablish the threshold annually, may require reporting by certain Subcontractors and Downstream Subcontractors regardless of materiality, and will communicate details of the materiality threshold and subsequent updates and/or changes through APLs or other instruction.

~~C~~**E.** The numerator of Contractor's**, Subcontractors', and Downstream Subcontractors'** MLR for a MLR reporting year is the sum of Contractor's**, Subcontractors', and Downstream Subcontractors'** incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

1) Contractor's**, Subcontractors', and Downstream Subcontractors'** Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor**, Subcontractors, and Downstream Subcontractors, as applicable,** paid to Providers, including under capitated contracts with

Network Providers, for Covered Services or supplies under this Contract**, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, as applicable,** and meeting the requirements of 42 CFR section 438.3(e);

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims Incurred but Not Reported;

iii. Withholds from payments made to Network Providers;

iv. Claims that are recoverable for anticipated coordination of benefits;

v. Claims payments recoveries received due to subrogation;

vi. Incurred but Not Reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

vii. Changes in other claims-related reserves; and

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

i. Overpayment recoveries received from Network Providers;

ii. Prescription Drug rebates received and accrued; and

iii. Amounts received as remittances from ~~Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors~~ **Subcontractors and Downstream Subcontractors, as applicable,** in accordance with Paragraph ~~K~~**P** of this provision and Exhibit B of this Contract. **Subcontractors and Downstream Subcontractors must deduct**

amounts received as remittances from their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

c) Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers; and

ii. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in ~~C.2.c~~ **E.2.c** of this provision.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

i. Non-claims costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and Utilization Management (UM); (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and (4) amounts paid for fines and penalties assessed by regulatory authorities; and

ii. Amounts paid to DHCS as remittances in accordance with Paragraph ~~K~~**P** of this provision and Exhibit B of this Contract; and

iii. Amounts paid to upstream entities as remittance in accordance with Paragraph P of this Subsection. The contracts between all

downstream entities in Contractor's delegation arrangement must include this reference; and

~~iii~~ **iv**. Amounts paid to Network Providers under 42 CFR section 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor's**, Subcontractors', and Downstream Subcontractors', as applicable,** activity that meets the requirements of 45 CFR section 158.150(b) and is not excluded under 45 CFR section 158.150(c);

b) Contractor's**, Subcontractors', and Downstream Subcontractors', as applicable,** activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

c) ~~Any~~ Contractor**'s, Subcontractors', and Downstream Subcontractors', as applicable,** expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this ~~provision~~**Subsection**.

3) Contractor's**, Subcontractors', and Downstream Subcontractors', as applicable,** expenditures on activities related to Fraud prevention as described in 45 CFR part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph ~~C~~**E**.1.c.ii of this ~~provision~~**Subsection**.

~~D~~**F**. The denominator of Contractor's**, Subcontractors', and Downstream Subcontractors'** MLR for a MLR reporting year must equal the adjusted premium revenue for Contractor's**, Subcontractors', and Downstream Subcontractors'** Medi-Cal line of business. The adjusted premium revenue is Contractor's**, Subcontractors', and Downstream Subcontractors'** premium revenue minus Contractor's**, Subcontractors', and Downstream Subcontractors'** federal, State, and local taxes and

licensing and regulatory fees, and is aggregated in accordance with this ~~provision~~**Subsection**.

1) Premium revenue includes the following for the MLR reporting year:

   a) Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

   b) One-time payments for Member life events as specified in this Contract, including, but not limited to, Supplemental Payments and Additional Payments as set forth in provisions 1.7 and 1.8 of Exhibit B, respectively;

   c) Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

   d) All changes to unearned premium reserves; and

   e) Net payments or receipts related to Risk Sharing Mechanisms developed in accordance with 42 CFR sections 438.5 or 438.6.

   f) Notwithstanding (a)-(c), for Subcontractors and Downstream Subcontractors, premium revenue includes all payments received pursuant to a Subcontractor Agreement or Downstream Subcontractor Agreement, excluding payments received in accordance with 42 CFR section 438.6(d).

2) Taxes, licensing, and regulatory fees for the MLR reporting year must include:

   a) Statutory assessments to defray the operating expenses of any State or federal department;

   b) Examination fees in lieu of premium taxes as specified by State law;

   c) Federal taxes and assessments allocated to Contractor, **Subcontractors, or Downstream Subcontractors, as applicable,** excluding federal income taxes on investment income, capital gains, and federal employment taxes;

d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor**, Subcontractors, and Downstream Subcontractors, as applicable,** that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

i. 3 percent of earned premium; or

ii. The highest premium tax rate in the State, multiplied by Contractor's**, Subcontractors', or Downstream Subcontractors', as applicable,** earned premium in the State.

3) If Contractor**, or any Subcontractor or Downstream Subcontractor,** is later assumed by another entity that becomes the new Contractor**, Subcontractor, or Downstream Subcontractor** under this Contract**, a Subcontractor Agreement, or a Downstream Subcontractor Agreement,** the new Contractor**, Subcontractor, or Downstream Subcontractors** must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, **Subcontractor, or Downstream Subcontractor.**

~~E~~**G**. In the allocation of expense, Contractor**, Subcontractors, and Downstream Subcontractors** must include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor**, Subcontractors, and Downstream Subcontractors** must use the following methods to allocate expenses:

1) Allocation to each category must be based on a **Generally Accepted Accounting Principles** (GAAP) method that is expected to yield the most accurate results;

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

3) Expenses that relate solely to the operation of a reporting entity, such as staff costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

~~F~~**H**. Contractor**, Subcontractors, and Downstream Subcontractors** may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

1) Contractor, **Subcontractors, and Downstream Subcontractors** may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2) ~~If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this provision.~~ **If Contractor's, Subcontractors, or Downstream Subcontractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Subsection.**

3) Non-credible and partially-credible Contractors, Subcontractors, and Downstream Subcontractors that meet the materiality threshold must submit an MLR report

regardless of credibility.

~~3~~**4**) Contractor**, Subcontractors, and Downstream Subcontractors** must fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with 42 CFR section 438.8(h)(4).

5) Contractor must submit a MLR report regardless of credibility. DHCS may require MLR reporting by certain Subcontractors or Downstream Subcontractors regardless of credibility.

~~G~~**I**. Contractor, **Subcontractors, and Downstream Subcontractors** must aggregate data by Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

J. Contractor must report its MLR to DHCS by county or rating region. Subcontractors and Downstream Subcontractors must report their MLR at the Subcontractor or Downstream Subcontractor arrangement level, by county or rating region, to their upstream entity.

~~H~~**K**. MLR Reporting requirements.

1) Contractor**, Subcontractors, and Downstream Subcontractors** must submit a report to DHCS that includes at least the following information for each MLR reporting year:

a) Total incurred claims;

b) Expenditures on Quality Improvement activities;

c) Expenditures related to activities compliant with 42 CFR sections 438.608(a) – (5), (7), (8), and (b);

d) Non-claims costs;

e) Premium revenue;

f) Taxes, licensing, and regulatory fees;

g) Methodology(ies) for allocation of expenditures;

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

k) A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

l) A description of the method used to aggregate data; and

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year.

3) Contractor must require any **Subcontractor or other** third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 calendar days from the end of the MLR reporting year, or within 30 calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor must require Subcontractors impose reporting requirements equivalent to the information required in 42 CFR section 438.8(k) on Downstream Subcontractors who accept financial risk to perform delegated activities and reporting responsibilities specific for those services they do not directly provide to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance and provisions of this Contract, in accordance with 42 CFR section 438.230(c)(2).

5) Contractor**, Subcontractors, and Downstream Subcontractors** must attest to the accuracy of the MLR calculation in accordance with requirements of this provision when submitting the MLR report.

6) Contractor must ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). Contractor is expected to review and provide oversight of Subcontractor MLR submissions. Specific expectations include, but are not to be limited to:

a) **Review of each applicable Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers;**

b) **Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;**

c) **Verification that reported expenses align with service volume reported in encounters;**

d) **Verification that reported revenues align with the upstream entities' reported payments;**

e) **Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business;**

f) **Review of the reasonableness of IBNR estimates.**

Contractor will impose the aforementioned review and oversight expectations on Subcontractors and Downstream Subcontractors, as applicable, for their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include a reference to Exhibit A, Attachment III, Subsection 1.2.5.K.4 and 6 (*Medical Loss Ratio*).

~~I~~**L**. Contractor may be excluded from the **reporting** requirements in this provision in the first MLR reporting year of its operation. Contractor then must comply with these requirements beginning with the next MLR reporting year in which it contracts with DHCS, even if the first MLR reporting year was not a full 12 months.

M. Consistent with 42 CFR section 438.8(l), Contractor may exempt newly contracted Subcontractors and Downstream Subcontractors from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first MLR reporting year of its operation. Contractor then must require Subcontractors and Downstream Subcontractors to comply with the MLR reporting year requirements in the next reporting year even if the first MLR reporting year did not cover a full 12 months of operation.

1) **Contractors must report any excluded Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of that MLR reporting year utilizing DHCS' reporting form.**

2) **DHCS retains the discretion to reverse any exemption based on information obtained during the initial review of MLR reporting and/or subsequent State or federal reviews or audits. Contractor must comply, and must require their Subcontractors and Downstream Subcontractors to comply, with any such reversal and submit or amend MLR reporting as needed.**

~~J~~**N**. In any instance where ~~there is~~ **DHCS makes** a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the reporting requirements in this ~~provision~~ **Subsection**.

O. Contractor must impose the above retroactive reporting requirements on its Subcontractors and Downstream Subcontractors where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to Contractor or upstream Subcontractor. In its sole discretion, DHCS reserves the right to limit MLR re-reporting for Subcontractors and Downstream Subcontractors to no more than one instance and may require re-reporting on an ad hoc basis. Subcontractors and Downstream Subcontractors must not re-report a MLR more than once for any MLR reporting year absent DHCS' review and express permission for any such MLR re-reporting. DHCS has the sole authority and discretion to grant or deny permission to any request for a Subcontractor or Downstream Subcontractor to re-report more than once for any MLR reporting year. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

~~K.~~**P.** Contractor must, if applicable, provide a remittance for a MLR reporting year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its ~~Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors,~~

~~and Downstream Partially Delegated Subcontractors~~ **Subcontractors and Downstream Subcontractors**.

Q. In accordance with the CalAIM 1915(b) Waiver STCs, DHCS will work with CMS to effectuate an audit of MLR reports no sooner than the 2028 calendar year. The MLR audit will include the time period covered by the CalAIM 1915(b) Waiver (January 1, 2022 through December 31, 2026).

1) To allow DHCS and CMS to complete an accurate audit of the MLR reports, Contractors, Subcontractors, and Downstream Subcontractors must maintain all records and documents relating to MLR reports for a minimum of 10 years as described in 42 CFR section 438.3(u).

2) Pursuant to 42 CFR section 438.3(h), DHCS and its contractor(s) may, at any time, request, inspect, and audit any of Contractor's, Subcontractors', and Downstream Subcontractors' records or documents. Record retention requirements are also referenced in Exhibit E of this Contract.

1.2.6 Contractor's Obligations

A. Contractor is required to provide any other financial reports, data, or information not listed above as requested by DHCS to evaluate or monitor Contractor's financial condition.

B. If Contractor's incurred claims reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5, Paragraph C.1.a.iii above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withholds.

1.2.7 Community Reinvestment Plan and Report

A. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must annually submit a Community Reinvestment Plan for DHCS' approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Plan must detail the expected Members of Contractor's community reinvestment, how they will benefit, and any additional information requested by DHCS. DHCS will make available the parameters for

allowable community reinvestment activities through APLs or similar guidance.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require the Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor to annually submit a Community Reinvestment Plan for approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section, 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. Contractor must submit the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's Community Reinvestment Plan to DHCS.

C. Contractor must annually submit a Community Reinvestment Report, including information related to any Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's Community Reinvestment Plan, to DHCS in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

1.3.1 Compliance Program
1.3.2 Fraud Prevention Program
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers
1.3.5 Disclosures
1.3.6 Treatment of Overpayment Recoveries
1.3.7 Federal False Claims Act Compliance and Support

1.3 Program Integrity and Compliance Program

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*). In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 Code of Federal Regulations (CFR) section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractor may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

Contractors must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

1.3.1 Compliance Program

Contractor must have a compliance program that includes, at a minimum, the following elements:

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

2) Includes reference to the standards of conduct or code of conduct;

3) Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

4) Details how it will implement and maintain elements of the compliance program;

5) Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

6) References the delegation reporting and compliance plan

7) References policies and procedures operationalizing the compliance program;

8) Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than annually; and

9) Is publicly posted on Contractor's website.

B. Standard of conduct or code of conduct must clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees, officers, board of directors, Network Providers, Subcontractors, and Downstream Contractors act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors annually.

C. Written policies and procedures which address the following:

1) Detail how elements of the compliance program are operationalized, including the titles of persons responsible for specific activities;

2) Describe how Contractor will oversee all Network Providers, Subcontractors, Downstream Subcontractors, and third-party entities compliance with all applicable terms and conditions of the Contract. See also, Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); and

3) Outline Contractor's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

D. A delegation reporting and compliance plan as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*) and Exhibit J *(Delegation Reporting and Compliance Plan)*;

E. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

F. The establishment of a regulatory compliance and oversight committee of the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members to the committee. The committee must review the compliance plan on an annual basis. The committee must meet at least quarterly to oversee the compliance program, including, reviewing areas of non-compliance and implementation and monitoring of corrective actions.

G. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings must address Contractor's standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

H. A system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

1) Compliance officer, senior management, and employees training and education on the overall compliance program, Fraud, Waste, and Abuse, and code of conduct in accordance with Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Plan*);

2) Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in

accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (*Members Rights and Responsibilities*);

3) Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (*Member Services Staff*) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*); and

4) For staff carrying out obligations under MOUs, the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

I. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors, Downstream Subcontractors, and Network Providers, as applicable. Lines of communication must be accessible to all employees, and include a mechanism to enable anonymous and confidential good faith reporting of potential compliance issues by any employee, Member, Network Provider, Subcontractor, or other person or entity, as they are identified.

J. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to:

1) Establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

2) To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of ten years years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

K. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1) Dedicated staff for routine internal monitoring and auditing of compliance risks;

2) Methods and tools for assessing whether Contractor activities required under this Contract comply with State and federal law and this Contract f. This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance;

3) Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and

4) Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

L. Contractor must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

1) This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

2) Corrective action plans must be reviewed and signed by the compliance officer and the executive officer responsible for the area subject to the Corrective Action plan;

To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of corrective action plans and description of outcomes; and

3) Contractor must ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

1.3.2 Fraud Prevention Program

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures for the elements identified in this Exhibit A, Attachment III, Subsection 1.3.2 (*Fraud Prevention Program*).

A. Fraud Prevention Officer

Contractor must designate a Fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor’s Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The Fraud prevention officer must attend and participate in DHCS’ quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the Fraud prevention officer.

B. Notification of Changes in Member’s Circumstances

Contractor must promptly notify DHCS when Contractor receives information about changes in a Member’s circumstances that may affect the Member’s eligibility including changes in the Member’s residence, income, insurance status, and death (42 CFR section 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through All Plan Letters (APLs), or other similar instructions.

C. Method to Verify Services Received

Contractor must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members (42 CFR section 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instruction.

D. Contractor’s Reporting Obligations

In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that

Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, its Downstream Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2) Completed Investigation Report

Within ten Working Days of completing its Fraud, Waste, or Abuse investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other State and federal agencies.

3) Quarterly Fraud, Waste, Abuse Status Report

Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents,

and any additional documents requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instructions.

5) Contractor's Obligation to Investigate State, federal, and other Medi-Cal managed care plans' Referrals of Fraud, Waste, and Abuse.

DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, Downstream Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*), in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6) Confidentiality

Contractor acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor, Downstream Subcontractor, or

Network Provider, Contractor must ensure that Subcontractor, Downstream Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor, Downstream Subcontractor, and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements.

1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing

A. Screening and Enrolling

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1) If Contractor chooses not to utilize the State level Enrollment pathway, Contractor must notify DHCS and send to DHCS its policies and procedures for review and approval before conducting its own Enrollment process.

2) Contractor may allow Network Providers to participate in their Network for up to 120 calendar days if the Network Provider has a pending Enrollment application in review with DHCS or with Contractor in accordance with 42 CFR section 438.602(b)(2).

3) Contractor must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied Enrollment in the Medi-Cal program, or upon the expiration of the first 120-day period. Contractor cannot continue to contract with providers during the period in which the provider resubmits its Enrollment application to DHCS or Contractor and can only re-initiate a contract upon the provider's successful enrollment.

B. Credentialing/Recredentialing

Contractor has an on-going obligation to credential and recredential Providers and Network Providers in accordance with this Contract (Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*)), applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers

Contractor has a continuing obligation to verify that Contractor's Network Providers are enrolled and remain enrolled in the Medi-Cal program. Contractor is responsible for knowledge of all ineligible Providers and individuals on these lists.

A. Tracking Suspended, Excluded, and Ineligible Providers

Contractor must review the following exclusionary databases and lists no less frequently than monthly and take appropriate action in accordance with APL 15-026 and APL 21-003.

1) List of Suspended and Ineligible Providers located at https://www.medi-cal.ca.gov;

2) List of excluded individuals and entities maintained by the U.S. Department of Health and Human Services (U.S. DHHS), Office of Inspector General located at https://oig.hhs.gov;

3) The System of Award Management (SAM);

4) The Social Security Administration Death Master File (SSADMF);

5) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and

6) Restricted Provider Database

Contractor must notify DHCS' PIU within ten Working Days of removing a suspended, excluded, or ineligible Providers or individual from its Network and confirm that the ineligible Provider is no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. A suspended, excluded, and ineligible Provider report must be sent to DHCS PIU in a manner prescribed by DHCS' PIU.

B. No Contracts with Excluded, Suspended, or Ineligible Providers

Contractor is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with Providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the

Medicare or Medi-Cal programs (42 CFR section 438.610(a)-(c) and APL 21-003).

C. Notification and Termination of Contracts

Contractor must promptly notify DHCS when Contractor receives information about a change in a Network Provider's, Subcontractor's, or Downstream Subcontractor's circumstances that may affect the Network Provider's, Subcontractor's, or Downstream Subcontractor's eligibility to participate in the Medi-Cal managed care program, including the termination of their Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement with Contractor in accordance with this Contract, State and federal law, including 42 CFR section 438.608(a)(4), and APL 21-003.

D. Actions to be taken where Credible Allegation of Fraud

If DHCS, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or United States Department of Justice (US DOJ), or any other authorized State or federal agency, determines there is a credible allegation of Fraud against Contractor's Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must comply with this Contract, all applicable State and federal laws, APL 15-026, and APL 21-003. Contractor must have procedures in place to immediately suspend payments to Subcontractors, Downstream Subcontractors, and Network Providers for which a State or federal agency determines there is a credible allegation of Fraud (42 CFR section 438.608(a)(8)). In addition, Contractor may conduct additional monitoring, temporarily suspend, and/or terminate the Network Provider, Subcontractor, or Downstream Subcontractor.

1.3.5 Disclosures

In accordance with 42 CFR section 438.608(c), Contractor, its Subcontractors, and its Downstream Subcontractors must:

A. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610; and

B. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104.

C. Report and return any payment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

Contractor must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of overpayments, as set forth in APL 23-011. **APL 23-011 requires Contractor to notify DHCS of any identified or recovered overpayments to a Provider due to potential fraud, waste or abuse. Contractor must notify its Managed Care Operations Division (MCOD) Contract Manager (CM) within 10 calendar days of the date that the overpayment, and the DHCS Audits and Investigations Unit regardless of the amount.**

Contractor must split equally overpayment recoveries of $25 million or more with DHCS. Contractor must report an overpayment of $25 million or more to DHCS through their assigned Managed Care Operations Division (MCOD) Contract Manager (CM) Within 60 calendar days of the date that the overpayment. In addition, Contractor must comply with this Contract, and all applicable State and federal law regarding overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

A Contractor can retain each overpayment recovery that is less than $25 million. Contractor is required to report all overpayments in their annual report to DHCS, using the rate development template, including recoveries that are less than $25 million. Contractor does not need to report overpayments that are less than $25 million within 60 calendar days of when the overpayment was identified.

B. Annual Report

Contractor must annually report to DHCS its recoveries of overpayments using the rate development (42 CFR section 438.608(d)(3)).

1.3.7 Federal False Claims Act Compliance and Support

A. Employee Education about False Claims Recovery

Contractor must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed

information about the False Claims Act and other federal and State laws described in 42 United States Code (USC) section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers (See also 42 CFR section 438.608(a)(6)).

Upon request by DHCS, Contractor must demonstrate compliance with this Exhibit A, Attachment III, Subsection 1.3.7.A (*Employee Education about False Claims Recovery*), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

B. Cooperation with the Office of the Attorney General, DMFEA, or the US DOJ Investigations and Prosecutions.

Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA or the US DOJ. Contractor's cooperation must include, but is not limited to, providing upon request, information, and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

C. Money Recovered from State Action Belongs to the State

In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA's or US DOJ's prosecution of a Subcontractor, Downstream Subcontractor, or Network Provider under the California False Claims Act (Government Code (GC) § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

D. Payment to Contractor is from Government Funds

Medi-Cal payments to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover overpayments made to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs as set forth in part in Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud

involving such government funds under the California False Claims Act (GC § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws.

E. Contractor's Settlements with Subcontractors, Downstream Subcontractors, and Network Providers do not bind DHCS, DMFEA, or the US DOJ.

Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, Downstream Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, Downstream Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, Downstream Subcontractor, or Network Provider.

Exhibit A, ATTACHMENT III

2.0 Systems and Processes

DHCS is committed to ensuring Contractors have the capabilities, systems and processes that enable delivery of high-quality health care. The provisions in this Article lay out DHCS' expectations of Contractors to have Management Information Systems (MIS) to collect, report, and analyze data to identify Members' needs and support Population Health Management. Contractors must be able to not only submit Encounter Data, but have systems to ensure the data are complete, accurate, reasonable, and timely, including for Subcontractors, Downstream Subcontractors, and Network Providers.

The provisions of this Article are also intended to ensure that Medi-Cal systems and processes are innovative and adapting to the way in which Members seek and access care. DHCS expects Contractors to build upon their MIS capabilities to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) Networks. Further, Contractors must comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule set forth at CMS-9115-F and ensure **that they and** their Subcontractors, Downstream Subcontractors, and Network Providers have the system capabilities to comply with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290. These requirements will enable the delivery system to have information for Members where and when they need care.

To further drive standards of high quality care and Health Equity, this Article includes provisions requiring Contractors to have both National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Further, DHCS specifies alignment of Quality Improvement and Health Equity activities that align in principle with the DHCS Comprehensive Quality Strategy and imposes requirements for Contractors to **meet or** exceed minimum performance standards.

DHCS is committed to transparency to demonstrate accountability to the public and community it serves. Consequently, DHCS requires public reporting of information related to access, quality, delegation, quality improvement, and Health Equity activities. Specific to public posting, this Article includes provisions requiring Contractors to make available on their websites their annual Quality Improvement and Health Equity Transformation Plan, meeting minutes from their Quality Improvement and Health Equity Committee (QIHEC), and Utilization Management policies and procedures.

2.1 Management Information System

2.1.1 Management Information System Capability
2.1.2 Encounter Data Reporting
2.1.3 Participation in the State Drug Rebate Program
2.1.4 Network Provider Data Reporting
2.1.5 Program Data Reporting
2.1.6 Template Data Reporting
2.1.7 Management Information System/Data Audits
2.1.8 Management Information System/Data Correspondence
2.1.9. Tracking and Submitting Alternative Format Selections
2.1.10 Interoperability Application Programming Interface System Requirements

2.1 Management Information System

2.1.1 Management Information System Capability

Contractor's Management and Information System (MIS) must be fully compliant with 42 Code of Federal Regulations (CFR) section 438.242 requirements and must have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. Contractor must make available to DHCS and to the Centers for Medicare & Medicaid Services (CMS) upon request all data related to this Contract.

A. Contractor must have and maintain a MIS that supports, at a minimum:

1) All Medi-Cal eligibility data;

2) Information on Members enrolled with Contractor,

3) Provider claims status and payment data;

4) Health care services delivery Encounter Data;

5) Network Provider Data;

6) Program Data;

7) Template Data;

8) Screening and assessment data;

9) Referrals including tracking of referred services to follow up with Members to ensure that services were rendered;

10) Electronic health records;

11) Prior Authorization requests and a specialty referral system as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

12) Complex Care Management (CCM) Care Manager assignment as specified in Exhibit A, Attachment III, Subsection 4.3.7 *(Care Management Programs*);

13) Financial information as specified in Exhibit A, Attachment III, Subsection 1.2.2 (*Contractor's Financial Reporting Obligations*);

14) Social Drivers of Health (SDOH) data per All Plan Letter (APL) 21-009;

15) Member and Member's Authorized Representative (AR) Alternative Format Selection(s) (AFS); and

16) Data sources specified in DHCS policies and guidance, including APLs, the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, ~~and~~ the Population Health Management (PHM) Policy Guide**, and the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Re-entry Initiative.**

B. Contractor's MIS must have processes that support the interactions between financial data, Member/eligibility data, Network Provider Data, Encounter Data, claims data, Program Data, Template Data, quality management/quality improvement/Utilization Management data, and report generation subsystems. The interactions of Contractor's MIS subsystems must be interoperable, efficient, and successful with Contractor's other MIS subsystems and DHCS' systems and processes.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Downstream Subcontractors, Network Providers, other State and federal and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. Data that must be able to be transmitted and consumed include, but are not limited to:

1) Encounter Data;

2) Fee-For-Service (FFS) claims data; including carved-out claims data, such as Medically Necessary services carved out of this Contract and data available from partner organizations, including but not limited to the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services;

3) Dental claims data;

4) Specialty mental health data;

5) Substance Use Disorder (SUD) data;

6) Medi-Cal FFS Treatment Authorization Request data;

7) California Children's Services (CCS) Program data;

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

Contractor must have processes in place for utilizing all data made available in order to meet the requirements for and support of Care Coordination, other administrative functions of the Contract with DHCS, and Operational Readiness Requirements and Deliverables as described in Exhibit A, Attachment II.

D. Contractor must implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a Provider Directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818 and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Encounter Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Encounter Data regardless of contracting arrangements or whether the Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider is reimbursed on a FFS or capitated basis.

D. Contractor must submit complete, accurate, reasonable, and timely Encounter Data within six Working Days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS will review and validate Contractor’s Encounter Data, including Encounter Data submitted by Contractor on behalf of its Subcontractors, Downstream Subcontractors, and Network Providers, for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor’s Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data.

G. DHCS or its agent will periodically, but not less frequently than once every three years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Subsection 2.2.9.E (*Encounter Data Validation*).

2.1.3 Participation in the State Drug Rebate Program

A. Contractor must participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in 42 United States Code (USC) section 1396r - 8(k)(2).

1) Encounter Data for outpatient drugs must comply with 42 USC section 1396r - 8(b)(1)(A); and

2) All outpatient drug Encounter Data must include, at a minimum, the total number of units of each dosage form, strength, and package size, by 11 numeric digit National Drug Code (NDC), for each claim, including eligible Physician administered drug claims.

B. Pursuant to 42 CFR section 438.3(s), Contractor must ensure that Encounter Data for outpatient drugs from participating organizations or covered entities in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC section 256b(a)(5)(A)(i). Contractor must also comply with the provisions of Welfare and Institutions Code (W&I) section 14105.46.

C. Contractor must assist DHCS in resolving manufacturer rebate disputes related to Network Provider Data or Encounter Data submissions. Encounter Data identified by DHCS or Contractor as having inaccurate or incomplete units, NDCs, procedure codes, 340B identifiers, or other data elements necessary to resolve manufacturer drug rebate disputes are required to be corrected and resubmitted in compliance with APLs.

2.1.4 Network Provider Data Reporting

A. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, and Downstream Subcontractor data to DHCS, as defined in State and federal law, APLs, DHCS 274 companion guide, and this Contract, that accurately represents Contractor's Network, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Network Provider Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and

timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Network Provider Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

E. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data.

2.1.5 Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Program Data to DHCS, as defined in State and federal law, APLs, and this Contract, including, but not limited to, all Grievances, Appeals, referrals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider (PCP) and Risk Tier assignments received or determined by Contractor, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

Program Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Program Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers must comply with this Subsection for submission of Program Data to Contractor.

E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

2.1.6 Template Data Reporting

A. Contractor must maintain a MIS that collects and reports Template Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Template Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Template Data to Contractor to

ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Template Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Template Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Template Data on a regular basis, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Template Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors, and Network Providers must comply with this Subsection for submission of Template Data to Contractor.

E. DHCS will review and validate Contractor's Template Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Template Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Template Data, Contractor must ensure that corrected Template Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Template Data.

2.1.7 Management Information System/Data Audits

Contractor must conduct MIS and data audits to the extent directed by DHCS, in accordance with this Contract, APLs, or other similar instructions which will be no less frequently than once every three years.

2.1.8 Management Information System/Data Correspondence

When DHCS provides Contractor with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to Contractor's MIS system, Contractor must submit to DHCS a Corrective Action plan with measurable benchmarks within 15 calendar days from the date of DHCS' written notice to Contractor. DHCS will approve Contractor's Corrective Action plan or request revisions within 30 calendar days of receipt of Contractor's Corrective Action plan. If DHCS requests revisions, Contractor must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to

complete the Corrective Action plan as approved by DHCS will subject it to sanctions, pursuant to Exhibit E, Section 1.19 (*Sanctions*). DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans or have been subject to sanctions due to non-compliance under this Section.

2.1.9. Tracking and Submitting Alternative Format Selections

A. Contractor must have and maintain systems that are able to, at a minimum, perform the following functions:

1) Collect and store Member Alternative Format Selection (AFS), as well as the AFS of a Member's AR;

2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002; and

3) Track Member's AR AFS data and submit to DHCS when requested.

B. Contractor must submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in APL 22-002.

C. After Contractor's one-time file upload is completed, Contractor must submit to DHCS all new Member AFS at the time of the Member's request. Contractor must send submissions online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.

D. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternative Format Database. The DHCS weekly file data elements and file path are included in the APL 22-002 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.

E. Contractor must submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

2.1.10 Interoperability Application Programming Interface System Requirements

A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment III, Section 2.1.2 (*Encounter Data*

Reporting), to data collected and made available through its API, Contractor must verify that data collected from Network Providers, Subcontractors, and Downstream Subcontractors to be made available through the API is complete, accurate, reasonable, and timely, and collected in accordance with the oversight and monitoring requirements in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

B. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

C. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines that continued access presents an unacceptable level of risk to the security of protected health information on its systems. Contractor's determination must be made in accordance with the requirements provided in APL 22-026.

Exhibit A, ATTACHMENT III

2.2 Quality Improvement and Health Equity Transformation Program

2.2.1 Quality Improvement and Health Equity Transformation Program Overview
2.2.2 Governing Board
2.2.3 Quality Improvement and Health Equity Committee
2.2.4 Provider Participation
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures
2.2.7 Quality Improvement and Health Equity Annual Plan
2.2.8 National Committee for Quality Assurance Accreditation
2.2.9 External Quality Review Requirements
2.2.10 Quality Care for Children
2.2.11 ~~Quality Monitoring for~~ Skilled Nursing Facilities—Long-Term Care
2.2.12 Disease Surveillance
2.2.13 Credentialing and Recredentialing

2.2 Quality Improvement and Health Equity Transformation Program

Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, and 28 California Code of Regulations (CCR) section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and and a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas:

1) Clinical quality of physical health care;

2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;

3) Access to primary and specialty health care Providers and services;

4) Availability and regular engagement with Primary Care Providers (PCP);

5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and

6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.

B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor’s service delivery system through analysis, evaluation, and systematic enhancements of the following:

1) Quantitative and qualitative data collection and data-driven decision-making;

2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and

4) Other issues identified by Contractor or DHCS.

C. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and

2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.

2.2.1 Quality Improvement and Health Equity Transformation Program Overview

Contractor must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of Contractor’s Governing Board;

B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor’s medical director or the medical director’s designee, in collaboration with Contractor’s Chief Health Equity Officer;

C. Supervision of QIHETP activities by Contractor’s medical director and the Chief Health Equity Officer; and

D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health

Workers (CHWs), and other non-clinical Providers in the process of QIHETP development and performance review.

2.2.2 Governing Board

Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum:

A. Approving the overall QIHETP and the annual plan of the QIHETP;

B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP;

C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made; and

D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.

2.2.3 Quality Improvement and Health Equity Committee

A. Contractor must implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures,

utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC);

2) Institute actions to address performance deficiencies, including policy recommendations; and

3) Ensure appropriate follow-up of identified performance deficiencies.

B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.

C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS upon request.

D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

2.2.4 Provider Participation

Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities

A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable:

1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor;

2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance;

3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports;

4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor; and

5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.

B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum:

1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following:

A. Contractor's commitment to the delivery of quality and equitable health care services;

B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff;

C. Qualification and identification of staff who are responsible for QI and Health Equity activities;

D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers;

E. The role, structure, and function of the QIHEC;

F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:

1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and

3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*).

H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee;

I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;

2) Consider the needs of Members;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;

4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and

5) Are reviewed and updated at least every two years;

J. The inclusion of Population Health Management (PHM) activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

K. Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*.;

M. Mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient Prescription Drugs;

N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and Welfare and Institutions Code (W&I) sections 14197 and 14197.04;

O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and

P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, CSHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children receiving Child welfare services.

2.2.7 Quality Improvement and Health Equity Annual Plan

<u>**Through regional quality and health equity teams,**</u> Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL.

A. Develop QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum:

1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;

5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services;

6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and

8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance

(NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

3) Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.

D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.

E. Contractor must attend regional collaborative meetings which may include additional regional partners including but not limited to county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).

2.2.8 National Committee for Quality Assurance Accreditation

Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every 3 years NCQA Health Plan Accreditation and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS.

In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full

NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA:

A. Accreditation status;

B. Survey type;

C. Results of the review;

D. Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data;

E. Recommended actions or improvements;

F. Corrective Action plans and summaries of findings; and

G. Expiration date of the accreditation.

Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.

Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status.

If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Sections 1.16 (*Termination*), 1.19 (*Sanctions*), and 1.20 (*Liquidated Damages*).

Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.

2.2.9 External Quality Review Requirements

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR section 438.310 *et seq*., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

A. Quality Performance Measures

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the **county or** reporting unit level and SNF level for certain measures

for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors

a) Contractor must calculate performance measure rates, to be verified by the EQRO;

b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

3) Contractor must **meet or** exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also **meet or** exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS.

4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

5) In accordance with 42 CFR section 438.700 *et seq.*, W&I section 14197.7, and Exhibit E, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet **or exceed** required MPLs as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also **meet or** exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to **meet or** exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.

B. PIPs

1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

4) Each PIP must include the following:

a) Measurement of performance using objective quality indicators;

b) Implementation of equity-focused interventions to achieve improvement in the access to and Quality of Care;

c) Evaluation of the effectiveness of the interventions based on the performance measures; and

d) Planning and initiation of activities for increasing or sustaining improvement.

5) Contractor must report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3) If Contractor has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.

D. Network Adequacy Validation

Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

As directed by DHCS, Contractor must participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

F. Focused Studies

As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of

quality outcomes and timeliness of, and access to, services provided by Contractor.

G. Technical Assistance

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

2.2.10 Quality Care for Children

Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

A. Scope of Services

1) Contractor must ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age in accordance with Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and American Academy of Pediatrics (AAP) Bright Futures preventive services to Members and their families. Additionally, Contractor must ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner;

4) Contractor must maintain Memorandums of Understanding (MOUs) with Local Health Departments (LHDs) and Local Government Agencies (LGAs), in Contractor's Service Area(s), including but not limited to California Children's Services (CCS), the Women, Infants and Children Supplemental Nutrition Program (WIC), maternal and Child health, social services, Regional Centers, and Child welfare

departments, as outlined in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) in order to facilitate the provision of EPSDT services to Members less than 21 years of age;

5) Contractor must comply with APL 23-005 requirements to include conducting ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including EPSDT services for Members less than 21 years of age as outlined in Exhibit A, Attachment III, Subsection 3.2.5.B (*Network Provider Training*), to ensure Providers are able to support Members and families in fully utilizing EPSDT services.

B. Utilization Management

Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) apply to the review and provision of Medically Necessary services for Members less than 21 years of age.

C. Population Health Management (PHM) and Coordination of Care

1) Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including the development of the annual PNA, apply to Members less than 21 years of age;

2) ~~HMS), as described in Exhibit A, Attachment III, Subsection 4.3.1 (*Population Health Management Program Requirements*), must contain a specific section focused on how the Contractor will provide PHM services to Members less than 21 years of age, including but not limited to, Basic PHM, EPSDT services, Care Coordination services, Early Intervention Services and a Wellness and Prevention Program;~~

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must provide a comprehensive wellness and prevention program to all Members less than 21 years of age, which includes but is not limited to (see full requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management))* initiatives, programs, and evidence-based approaches to improving access to preventive health visits, developmental screenings, and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*).

D. Network and Access to Care

1) Contractor must ensure that each Member less than 21 years of age has an assigned PCP as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*);

2) Contractor must provide information to all Network Providers regarding the Vaccines for Children (VFC) Program and is expected to promote and support Enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations; and

3) Contractor must maintain and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

E. Quality and Health Equity

1) Contractor must identify and address underutilization of Children's preventive services including but not limited to EPSDT services such as well Child visits, developmental screenings and immunizations;

2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*);

3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A,

Attachment III, Subsection 2.2.9.A.2 (*Quality Performance Measures*);

5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

7) Contractor must engage in a Member and family-oriented engagement strategy to QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection 5.2.11.D. (*Cultural and Linguistic Programs and Committees*).

F. Mental Health and Substance Use Disorder Services

Contractor must adhere to all requirements of Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*) for the provision of mental health and Substance Use Disorder services to Members less than 21 years of age, as appropriate, including collaborating with county Behavioral Health plans and complying with APL 23-010 and all mental health parity requirements in 42 CFR section 438.900 *et seq*.

Contractor must collaborate with the Department in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

To facilitate the provision of Medically Necessary services to Children, Contractor must collaborate with, and, by January 1, 2025 execute, an MOU with Local Education Agencies (LEAs) in each county within Contractor's Service Area for school-based services, including but not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. Contractor must also ensure that Members' PCP (PCP) cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs)

and ultimately ensure that care is coordinated regardless of financial responsibility, as outlined in Exhibit A, Attachment III, Subsections 4.3.16 (*School-Based Services*) and 5.6.1 (*MOU Purpose*).

2.2.11 ~~Quality Monitoring for~~ Skilled Nursing Facilities – Long-Term Care

Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G *(Services for All Members).* Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractors must have a system in place to collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.

2.2.12 Disease Surveillance

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

2.2.13 Credentialing and Recredentialing

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body.

A. Standards

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Subcontractor and Downstream Subcontractor Credentialing

Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

C. Credentialing Provider Organization Certification
Contractor may obtain Credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

D. Disciplinary Actions

Contractor must implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner, including dentists, to the appropriate authorities. Contractor must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating the privileges of practitioners, including dentists. Contractor must implement and maintain a Provider appeal process.

E. Medi-Cal and Medicare Provider Status

Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database. Contractor cannot maintain contracts with Network Providers, Subcontractors, or Downstream Subcontractors who

have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.

F. Contractor's NCQA Health Plan Accreditation

If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.

G. Credentialing of Other Non-Physician Providers

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives (CNMs), clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.

Exhibit A, ATTACHMENT III

2.3 Utilization Management Program

2.3.1 Prior Authorizations and Review Procedures
2.3.2 Timeframes for Medical Authorization
2.3.3 Review of Utilization Data
2.3.4 Delegating Utilization Management Activities

2.3 Utilization Management Program

Contractor must develop, implement, update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members. Contractor must ensure that its UM program:

A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health & Safety Code (H&S) section 1367.01, and qualified staff responsible for the UM program.

B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.

C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-Network Provider to provide the second opinion at no cost to the Member, in accordance with 42 Code of Federal Regulations (CFR) section 438.206.

D. Makes available to Network Providers all relevant UM policies and procedures upon request.

E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.

F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.

G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member's Primary Care Providers (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral must be made within four Working Days of the date that the proposed

treatment plan, if any, is submitted to Contractor's medical director or the medical director's designee, in accordance with H&S section 1374.16.

H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures.

I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.

J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

K. Makes Contractor's UM policies and procedures available to Members and Providers on Contractor's website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor in accordance with 42 CFR section 438.915.

1) Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.

2) Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.

3) Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

All UM activities must be performed in accordance with H&S sections 1363.5 and 1367.01 and 28 California Code of Regulations (CCR) section 1300.70(a)(3), (b)(2)(H), and (c).

2.3.1 Prior Authorizations and Review Procedures

Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&S section 1367.01:

A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;

B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions;

C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity. Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician's office, or outpatient setting;

medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter;

D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S section 1363.5;

E. Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor's health care professional responsible for the denial, delay, or modification;

F. Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*). Contractor must publish on its website an Appeals procedure for both Providers and Members;

G. Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member's medical condition requires time sensitive services;

H. Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments;

I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*);

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member or a Member's Provider for the provision of a Covered Service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing; and

K. All of Contractor's authorization requirements must comply with the requirements for parity in mental health and SUD benefits in 42 CFR section 438.900, et seq.

2.3.2 Timeframes for Medical Authorization

A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.

B. Post-Stabilization Care Services: Contractor must respond to a Network Provider's or out-of-Network Provider's request for authorization for Post-Stabilization Care Services within 30 minutes or the service is deemed approved, in accordance with All Plan Letter (APL) 23-009.

C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider's request for Post-Stabilization Care Services within 30 minutes or the service is deemed approved.

D. Retrospective Review Authorization Request for Treatment Received: Contractor must accept requests for Retrospective Review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the Member who received the services or to the Member's Authorized Representative (AR) within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S section 1367.01(h)(1).

E. Routine Authorizations: Contractor must respond to routine requests and concurrent requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor's receipt of the request, in accordance with 42 CFR section 438.210 and H&S section 1367.01.

F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S section

1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after Contractor's receipt of the request for services. All Contractors must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings including Contractor chosen Community Supports and make an authorization decision in a timeframe that is appropriate for the nature of the Member's condition but is no longer than 72 hours after Contractor's receipt of all information needed to make an authorization decision.

G. Hospice Services: Contractor may only require Prior Authorization for inpatient hospice care. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.

H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS APLs, Welfare and Institutions Code (W&I) section 14103.6, and H&S section 1367.01.

I. Physician Administered Drugs: For medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim, Contractor must comply with the same timeframes as other medical services, at set out in this subsection.

2.3.3 Review of Utilization Data

A. Contractor must include within the UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services. Contractor's internal reporting mechanisms used to detect Member utilization and Provider prescribing patterns must be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.6 (*Identifying Members for Community Supports)*.

C. Contractor must monitor and track Non-specialty Mental Health Services (NSMHS) utilization data for both Members. Upon request, Contractor must submit data to DHCS.

2.3.4 Delegating Utilization Management Activities

Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*).

Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

DHCS is committed to ensuring that all Contractors are aware of their obligations under this Contract and are committed to being accountable not only for their own obligations, but for those of their Subcontractors and Downstream Subcontractors for delegated functions. In this Article, DHCS includes provisions requiring Contractors to disclose what entities provide delegated functions through Subcontractor Agreements and Downstream Subcontractor Agreements as applicable.

In addition, Contractors are to demonstrate that they have robust compliance, monitoring, and oversight programs, including for all delegated entities to ensure Members receive quality care and have access to services. This Article requires Contractors to not only disclose delegation arrangements but include justification for the use of delegated entities to ensure that the Member's experience and outcomes are front and center. DHCS is particularly focused on those entities that take risk; thus this Article includes provisions requiring reporting of Subcontractors and Downstream Subcontractors that assume responsibility for taking that risk and managing the health care of a portion of assigned lives.

This Article articulates DHCS' commitment in moving the delivery system towards value-based payment. Contractors are to report on the proportion of spend that is tied to value. In addition, Contractors are to implement Financial Arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Such arrangements include, but are not limited to, incentive payment arrangements that reward Providers for high or improved performance on selected measures or benchmarks. Finally, Contractors are to report on the proportion of spend on Primary Care specifically in an effort to encourage investment in Primary Care as appropriate.

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics
3.1.8 Network Provider Agreements with Safety-Net Providers
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments
3.1.10 Nondiscrimination in Provider Contracts
3.1.11 Public Records
3.1.12 Requirement to Post

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations

A. Contractor is fully responsible for all duties and obligations set forth in this Contract. However, Contractor may enter into agreements with other individuals, groups, or entities to fulfill its obligations and duties under the Contract, including Network Provider Agreements and Subcontractor Agreements. Some individuals, groups, or entities may be a combination of Network Provider, Subcontractor, and/or Downstream Subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Contract, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as applicable.

B. Contractor must ensure that all Subcontractors and Downstream Subcontractors comply with all Contract requirements related to the delegated functions undertaken by each Subcontractor or Downstream Subcontractor. Contractor remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. To ensure Subcontractor's and Downstream Subcontractor's compliance, Contractor must, at a minimum, do the following:

1) Include all Contract duties and obligations relating to the delegated duties in the Subcontractor Agreement;

2) Ensure Subcontractor includes all Contract obligations relating to the delegated duties in all Downstream Subcontractor Agreements;

3) Provide policies and procedures to Subcontractors applicable to the delegated functions and ensure Subcontractor provides the relevant policies and procedures as applicable to delegated functions;

   Monitor and oversee all delegated functions, including those that may flow down to Downstream Subcontractors; and

4) Provide to DHCS a delegation reporting and compliance plan, as set forth in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's*

Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan).

C. Contractor must ensure that Network Providers comply with all applicable Contract requirements and all requirements set forth in their Network Provider Agreements (See Exhibit A, Attachment III, Subsection 3.1.5.A (*Network Provider Agreement Requirements).*

3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Submission and Approval of Network Provider Agreements Templates

1) Contractor must submit to DHCS all Network Provider Agreement templates, and any proposed amendments thereto, for review and approval before use. The contents of the Network Provider Agreement templates are set forth in All Plan Letter (APL) 19-001.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of all Network Provider Agreement templates. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS' review. If DHCS does not complete its review of Network Provider Agreement templates within 60 calendar days of receipt, or within DHCS' estimated date of completion, whichever is later, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

B. Submission and Approval of Subcontractor Agreements and Downstream Subcontractor Agreements Templates

1) Contractor must submit to DHCS all Subcontractor **Agreement** and Downstream Subcontractor Agreement templates, and any amendments thereto, as follows:

a) For Fully Delegated Subcontractors and Downstream **Fully Delegated** Subcontractors ~~Fully Delegated~~, Contractor must submit all Subcontractor **Agreement** and Downstream Subcontractor Agreement~~s~~ templates and any amendments thereto, to DHCS for review and approval before use. Contractor must also file with DHCS all executed Subcontractor Agreements with Fully Delegated Subcontractors and **all executed Downstream**

Subcontractor Agreements with Downstream **Fully Delegated** Subcontractors.

b) For Partially Delegated Subcontractors and Administrative Subcontractors, and Downstream Partially Delegated Subcontractors and Downstream Administrative Subcontractors, Contractor must submit all Subcontractor Agreements and Downstream Subcontractor Agreements templates, and any amendments thereto, to DHCS for review and approval prior to execution of the Subcontractor Agreement or Downstream Subcontractor Agreement.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of Subcontractor Agreement and Downstream Subcontractor Agreement templates and/or actual proposed Subcontractor Agreements and Downstream Subcontractor Agreements submitted by Contractor. DHCS will provide Contractor with a written explanation indicating whether the template and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement is approved, disapproved, or an estimated date for completion of DHCS review. If DHCS does not complete its review of the submitted material within 60 calendar days of receipt, or by DHCS estimated date of completion, whichever is later, Contractor may elect to implement or use the template and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan

A. Content of Delegation Reporting and Compliance Plan

Contractor must report its delegation and compliance plan using the templates provided in Exhibit J *(Delegation Reporting and Compliance Plan),* which includes, but is not limited to, the following:

1) All Contractor's contractual relationships with Subcontractors and Downstream Subcontractors;

2) Contractor's oversight responsibilities for all delegated obligations; and

3) How Contractor intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

B. Timing of Submission

Contractor must submit its delegation reporting and compliance plan to DHCS as follows:

1) During the operational readiness period;

2) Annually, whether or not changes have been made to its delegation structure; and

3) Anytime there is a change in the delegation reporting and compliance plan, including but not limited to a change in a Subcontractor and/or a change in the scope of the delegation.

The report must be submitted within 30 calendar days from either the beginning of the annual reporting period or any change, as identified above.

3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance

Contractor must maintain policies and procedures approved by DHCS to ensure that Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of this Contract and all duties delegated to Subcontractors and Downstream Subcontractors as set forth above. Contractor must evaluate each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions, must oversee and remain responsible and accountable for any services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor, and must meet all applicable requirements set forth in State and federal law, regulation, any APLs or DHCS guidance, and this Contract.

3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

1) Specification of the Covered Services to be ordered, referred, or rendered;

2) The term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;

4) Specification that the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to, Knox-Keene Health Care Service Plan Act of 1975 (KKA), Health and Safety Code (H&S) section 1340 *et seq*. (unless excluded under this Contract); Welfare and Institutions Code (W&I) sections 14000 and 14200 *et seq.*; 28 California Code of Regulations (CCR) section 1300.43 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

5) Network Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

6) Network Provider will submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as requested by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;

7) Network Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

8) Network Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access

Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

b) At all reasonable times at Network Provider's place of business or at such other mutually agreeable location in California.

9) Network Provider will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term annual of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Provider will timely gather, preserve and provide to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*);

11) Network Provider will assist Contractor, or if applicable a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) in the event of Contract termination, or in the event of termination of the Network Provider Agreement for any reason;

12) Network Providers will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

13) Network Provider will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;

14) Network Provider will not bill a Member for Medi-Cal Covered Services;

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

17) Network Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

18) Network Provider must notify Contractor, and Contractor's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*);

19) Network Provider must report to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, when it has received an overpayment; return the overpayment to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the overpayment was identified; and notify Contractor, or Contractor's Subcontractor or Downstream Subcontractor, in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 Code of Federal Regulations (CFR) section 438.608(d)(2);

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's

dispute resolution mechanism and submit a Grievance pursuant to H&S section 1367(h)(1).

21) **<u>Network Provider must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to H&S section 130290.</u>**

B. Subcontractor and Downstream Subcontractor Agreement Requirements

Subcontractor Agreements and Downstream Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement or that the Subcontractor or Downstream Subcontractor delegates in the Downstream Subcontractor Agreement:

1) Specification of Contractor's obligations and functions undertaken by the Subcontractor or Downstream Subcontractor;

2) The term of the Subcontractor Agreement or Downstream Subcontractor Agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service;

4) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement and amendments as set forth in this Exhibit A, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*);

5) Subcontractor's assignment or delegation of an obligation or responsibility under a Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

6) Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

7) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement is governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to 42 CFR section 438.230; KKA, H&S section 1340 *et seq*. (unless otherwise excluded under this Contract); 28 CFR section 1300.43 *et seq.*; W&I sections 14000 and 14200 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

8) Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

9) Language comparable to Exhibit A, Attachment III, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

10) Subcontractor and Downstream Subcontractors must submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports and data as requested by Contractor, in order for Contractor to meet its reporting requirements to DHCS;

11) Subcontractor and Downstream Subcontractors must comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

12) Subcontractor and Downstream Subcontractors must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

13) Subcontractor and Downstream Subcontractors must make all of their premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose

of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

b) At all reasonable times at Subcontractor's or Downstream Subcontractor's place of business or at such other mutually agreeable location in California.

14) Subcontractor and Downstream Subcontractors must maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

15) Subcontractor and Downstream Subcontractors must timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*).

16) Subcontractor and Downstream Subcontractors must assist Contractor as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*), in the event of Contract termination, or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

17) Subcontractor and Downstream Subcontractors must notify DHCS in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated for any reason;

18) Subcontractor and Downstream Subcontractors must hold harmless both the State and Members in the event Contractor, or another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

19) Subcontractor and Downstream Subcontractors must participate and cooperate in Contractor's Quality Improvement System as applicable;

20) If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement must include those provisions stipulated in Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*);

21) To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

22) Contractor must inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

23) Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

24) Subcontractor and Downstream Subcontractors must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for Subcontractor's and Downstream Subcontractor's staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

25) Subcontractor and Downstream Subcontractors must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

26) Subcontractor and Downstream Subcontractors must notify Contractor within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6) (*Confidentiality*);

27) Subcontractor and Downstream Subcontractors must report directly to Contractor, or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an overpayment; return the overpayment to Contractor within 60 calendar days after the date the overpayment was identified; and notify Contractor in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries) and* 42 CFR section 438.608(d)(2);

28) Subcontractor and Downstream Subcontractors must perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii); and

29) Express agreement and acknowledgement by Subcontractor and Downstream Subcontractors that DHCS is a direct beneficiary of the Subcontractor Agreement or Downstream Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement or Downstream Subcontractor Agreement.

30) Subcontractors and Downstream Subcontractors must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable, pursuant to H&S section 130290.

31) Specification of Subcontractors', including Downstream Subcontractors', MLR reporting and remittance obligations

pursuant to 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM SpecialTerms and Conditions (STCs), which include, but are not limited to, the requirements in:

a) **Exhibit A, Attachment III, Subsection 1.2.5.A.2 (*Medical Loss Ratio*) for the CalAIM 1915(b) STC downstream requirements and four-part test;**

b) **Exhibit A, Attachment III, Subsection 1.2.5.B (*Medical Loss Ratio*) for the MLR Experience Defined;**

c) **Exhibit A, Attachment III, Subsections 1.2.5. C and D (*Medical Loss Ratio*) for the Materiality Threshold;**

d) **Exhibit A, Attachment III, Subsection 1.2.5. E (*Medical Loss Ratio*) for the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;**

e) **Exhibit A, Attachment III, Subsection 1.2.5.E.1.b.iii (*Medical Loss Ratio*) for remittances received by Subcontractors and Downstream Subcontractors must be deducted from incurred claims;**

f) **Exhibit A, Attachment III, Subsection 1.2.5.E.1.e.iii (*Medical Loss Ratio*) for remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;**

g) **Exhibit A, Attachment III, Subsection 1.2.5.F (*Medical Loss Ratio*) for MLR denominator;**

h) **Exhibit A, Attachment III, Subsection 1.2.5.G (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor allocation of expenses;**

i) **Exhibit A, Attachment III, Subsection 1.2.5.H (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor credibility adjustments;**

j) **Exhibit A, Attachment III, Subsection 1.2.5.I (*Medical Loss Ratio*) for materiality threshold;**

k) **Exhibit A, Attachment III, Subsection 1.2.5.J (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;**

l) **Exhibit A, Attachment III, Subsection 1.2.5.K (*Medical Loss Ratio*) for general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;**

m) **Exhibit A, Attachment III, Subsection 1.2.5.K.4 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor reporting requirements on downstream entities that accept financial risk;**

n) **Exhibit A, Attachment III, Subsection 1.2.5.K.5 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;**

o) **Exhibit A, Attachment III, Subsection 1.2.5.K.6 (*Medical Loss Ratio*) for requirements for Subcontractor and Downstream MLR submissions and oversight requirements;**

p) **Exhibit A, Attachment III, Subsection 1.2.5.M (*Medical Loss Ratio*) for newer experience exemptions for Subcontractors and Downstream Subcontractors;**

q) **Exhibit A, Attachment III, Subsection 1.2.5.O (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year.**

r) **Exhibit A, Attachment III, Subsection 1.2.5.P (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor remittance requirements; and**

s) **Exhibit A, Attachment III, Subsection 1.2.5.Q (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor audit and record retention requirements.**

3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Medi-Cal managed care plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics.

3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics

Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with FQHCs, Rural Health Clinics (RHCs), and other clinics must meet the requirements of Exhibit A, Attachment III, Subsections 3.1.5.A and B (*Network Provider Agreement Requirements* and *Subcontractor and Downstream Subcontractor Agreement Requirements*), above, and the reimbursement requirements set forth in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)*. Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a Member.

3.1.8 Network Provider Agreements with Safety-Net Providers

A. Contractor must offer a Network Provider Agreement to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that Contractor requires of other similar Providers.

B. Contractor must notify DHCS of intent to terminate a Network Provider Agreement with a Safety-Net Provider at least 60 calendar days prior to the effective date of termination unless such Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination will be effective immediately, without DHCS prior approval, and Contractor must notify DHCS concurrently with the termination.

3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments

A. Contractor must negotiate in good faith and execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the Local Health Department (LHD) in each county within Contractor's Service Area for the following public health services:

1) Family Planning Services, as specified in Exhibit A, Attachment III, Subsection 3.3.9 (*Non-Contracting Family Planning Providers*);

2) Sexually Transmitted Disease (STD) services, as specified in Exhibit A, Attachment III, Subsection 3.3.10 (*Sexually Transmitted Disease*), including diagnosis and treatment of the following: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum, and granuloma inguinal;

3) Human Immunodeficiency Virus (HIV) testing and counseling as specified in Exhibit A, Attachment III, Subsection 3.3.11 (*Human Immunodeficiency Virus Testing and Counseling*); and

4) Immunizations as specified in Exhibit A, Attachment III, Subsection 3.3.12 (*Immunizations*).

B. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements must also meet the requirements described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

3.1.10 Nondiscrimination in Provider Contracts

Contractor must not discriminate against Providers, in connection with the participation, reimbursement, or indemnification of any Provider, who is acting within the scope of practice of their license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of Providers in its Network, it must give the affected

Providers written notice of the reason for its decision. Contractor's Provider selection policies must not discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. Upon request, Contractor must provide to DHCS its selection of Providers chosen to meet the need of Contractor's Members. This section will not be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of Contractor's Members, preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

3.1.11 Public Records

To the extent DHCS receives Contractor's Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than 5 percent of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than 5 percent of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

3.1.12 Requirement to Post

Contractor must post on its website a summary of its delegation model that outlines how it delegates obligations and duties of this Contract to Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

Exhibit A, ATTACHMENT III

3.2 Provider Relations

3.2.1 Exclusivity
3.2.2 Provider Dispute Resolution Mechanism
3.2.3 Out-of-Network Provider Relations
3.2.4 Contractor's Provider Manual
3.2.5 Network Provider Training
3.2.6 Emergency Department Protocols
3.2.7 Prohibited Punitive Action Against the Provider
3.2.8 Submittal of Inpatient Days Information

3.2 Provider Relations

3.2.1 Exclusivity

Contractor must not, by use of any exclusivity provision, clause, agreement, nor in any other way, prohibit any Network Provider from providing services to other persons enrolled in Medi-Cal who are not Contractor's Members.

3.2.2 Provider Dispute Resolution Mechanism

In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes.

A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

   1) The authorization or denial of a service;

   2) The processing of a payment or non-payment of a claim by Contractor; or

   3) The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement **per APL-23-020.**

B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors that provide services to Contractor's Members of its Provider Dispute Resolution Mechanism, regardless of contracting status.

D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation. ~~Contractor and the Network Provider or out-of-Network Provider may agree that additional time is needed. If Contractor unilaterally requests additional time, it must~~

~~show good cause for the extension and provide supporting good cause documentation to DHCS upon request.~~

E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section 1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor.

F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

3.2.3 Out-of-Network Provider Relations

A. Contractor must develop and maintain protocols for payment of claims to out-of-Network Providers, and for communicating and interacting with out-of-Network Providers regarding services and claims payment.

B. Contractor must provide its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management (UM) and Retrospective Review to all out-of-Network Providers providing services to its Members. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an out-of-Network Provider or anytime an out-of-Network Provider submits a claim for services provided to Contractor's Members.

3.2.4 Contractor's Provider Manual

Contractor must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding Medi-Cal Covered Services and responsibilities for the provision of services including Basic Population Health Management (Basic PHM); Care Coordination for Excluded Services; policies and procedures; quality assurance; improvement and monitoring; clinical protocols governing Prior Authorization and UM; timeliness standards; Credentialing; prohibited claims; statutes; regulations; telephone access; special requirements; data reporting; and the Member Grievance, Appeal, and State Hearing process. Contractor must ensure the most updated Provider manual is available through Provider portals, the internet, or upon

request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.

Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.

Contractor must conduct an annual review of its Provider manual and document that the review has been conducted by the appropriate Contractor committees including the QIC. Contractor must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

Contractor's Provider manual must include and inform Network Providers, Subcontractors, and Downstream Subcontractors of the following Member rights information, as set forth in Exhibit A, Attachment III, Section 5.1 (*Member Services*):

A. Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative (AR) or Provider appeal on the Member's behalf, with written consent from the Member;

B. Availability of assistance in filing a Grievance, Appeal, or State Hearing;

C. Toll-free numbers to file oral Grievances and Appeals;

D. Member's right to request continuation of benefits during an Appeal or State Hearing;

E. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and

F. Member's right to an Independent Medical Review (IMR), if applicable.

3.2.5 Network Provider Training

Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network

Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis.

A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.

B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate medical record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs.

C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training.

D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also provide training on how to refer and coordinate care for Members who need access to Excluded Services.

E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (*Member Services*), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural

competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This process must also include an educational program for Network Providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children with Special Health Care Needs (CSHCN). Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.

F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.

G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.

3.2.6 Emergency Department Protocols

Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:

A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;

B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Members who present at the emergency department for Non-Emergency services;

D. Procedures for emergency departments to report Contractor's system and/or protocol failures and Contractor's processes for correcting deficiencies when failures occur;

E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008,and APL 23-009;

F. Procedures for screening and referral of Members who meet Enhanced Care Management (ECM) Population of Focus eligibility criteria, especially the Individuals at risk for avoidable hospital or Emergency Department utilization Population of Focus; and

G. Procedures for screening and referral of Members who meet medical necessity eligibility criteria for Community Health Workers CHW services.

3.2.7 Prohibited Punitive Action Against the Provider

Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising, or advocating on behalf of, a Member about:

A. The Member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the Member needs in order to decide among all relevant treatment options;

B. The risks, benefits, and consequences of treatment or non-treatment; or

C. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.2.8 Submittal of Inpatient Days Information

Contractor must report hospital inpatient days to DHCS as required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Upon DHCS' written request, Contractor must also provide these reports for the time period and in the

form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor must submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

Exhibit A, ATTACHMENT III

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements
3.3.2 Capitation Arrangements
3.3.3 Provider Financial Incentive Program Payments
3.3.4 Identification of Responsible Payor
3.3.5 Claims Processing
3.3.6 Prohibited Claims
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers
3.3.9 Non-Contracting Family Planning Providers
3.3.10 Sexually Transmitted Disease
3.3.11 Human Immunodeficiency Virus Testing and Counseling
3.3.12 Immunizations
3.3.13 Community Based Adult Services
3.3.14 Organ and Bone Marrow Transplants
3.3.15 Long-Term Care Services
3.3.16 Emergency Services and Post-Stabilization Care Services
3.3.17 Provider-Preventable Conditions
3.3.18 Prohibition Against Payment to Excluded Providers
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements

A. Except as otherwise specified in this Contract, Contractor may compensate Providers as Contractor and Provider negotiate and agree.

B. DHCS encourages Contractor to utilize value-based and alternative payment models to compensate Network Providers, especially for Primary Care Covered Services, in ways that ensure Provider accountability for both quality and total cost of care with a focus on population health management. Contractor must monitor and must report, within 90 calendar days of DHCS' request, the number or amount, and percent, of Contractor's Members, Network Providers, and medical expenditures that are made under such payment models, separately for hospital services, professional services, and other services at a minimum.

C. Payment to support Networks based on value: To continue to build and strengthen Networks based on value, Contractors must support their Providers through value-based payment models that promote high-quality, affordable, and equitable care.

On an annual basis, as specified by DHCS, Contractor must report on its Network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories as outlined.

D. Effective Primary Care: Contractor must support effective Primary Care and integrated care through use of alternative payment models, such as population-based payment and shared savings. Specifically, Contractor must:

1) Ensure investment in Primary Care service delivery

a) Contractor must report on total Primary Care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP LAN APM Framework Category. Contractor must report the percentage of spend within each HCP LAN APM Framework Category as a percentage of its total spend.

b) Contract must stratify the reporting of Primary Care spend (and as a percentage of total spend) by age (Children and

youth ages zero to 20; adults ages 21+), by race/ethnicity, and as requested by DHCS.

c) Contractor must work with DHCS and other stakeholders to analyze the relationship between the percent of spend for Primary Care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase Primary Care spend improves quality or drives lower total cost of care, DHCS may set a target or floor for Primary Care spend in future requirements, and Contractor will be required to meet these targets for minimum Primary Care spend.

2) Ensure promotion of Primary Care delivery through alternative payment models

a) As specified by DHCS, Contractor must report on its Primary Care payment models using the HCP LAN APM Framework Categories.

b) As specified by DHCS, Contractor must report on an annual basis the number and percent of its contracted Primary Care clinicians paid using each HCP LAN APM Framework Category.

c) A description of Contractor's payment model for its five largest medical groups, as defined by the number of Providers, and how its Primary Care clinicians are paid. Contractor must adopt and progressively expand the percent of Primary Care clinicians paid through the HCP LAN APM Framework Categories of population-based payment (Category 4) and alternative payment models built on a fee-for-service structure such as shared savings (Category 3).

3.3.2 Capitation Arrangements

Payments by Contractor to a Network Provider on a capitation basis must be payable effective the date the Member's Enrollment is assigned to the Network Provider. Capitation Payments by Contractor to a Network Provider must be payable no later than 30 calendar days after the Member Assignment.

3.3.3 Provider Financial Incentive Program Payments

A. Contractor may compensate Providers through financial incentive program payments, so long as:

1) Financial incentive program payments to Providers are not designed to induce Providers to reduce or limit Medically Necessary Covered Services provided to a Member;

2) Financial incentive program payments comply with the requirements of All Plan Letter (APL) 19-005, where applicable; and

3) All financial incentive programs related to this Contract are reported in the form, manner, and frequency specified by DHCS.

B. Contractor may implement and maintain a physician incentive plan, as defined in 42 Code of Federal Regulations (CFR) section 422.208, so long as:

1) No specific payment is made directly or indirectly under the physician incentive plan as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member; and

2) The physician incentive plan complies with the requirements of 42 CFR sections 438.3(i) and 438.10(f)(3).

3.3.4 Identification of Responsible Payor

Contractor must provide information to **the** DHCS **fiscal intermediary** that identifies the payor(s) responsible for reimbursement of Covered Services provided to a Member. Contractor must identify the Network Provider, Subcontractor, or Downstream Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor must provide this information upon DHCS' request and in a manner prescribed by DHCS.

3.3.5 Claims Processing

Contractor must pay all Clean Claims submitted by Providers in accordance with this section, unless the Provider and Contractor have agreed in writing to an alternate payment schedule, subject to the following:

A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - 1371.36 and their implementing regulations. Contractor must be subject to any penalties and

sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 **calendar** days of receipt. For the purpose of establishing compliance thresholds,Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment. **Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment.**

C. Contractor must provide direct instruction, training, and technical assistance to its providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM providers; Community Support providers; Doulas, or other community-based providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is are required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent encounters, or bills or invoices.

D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.

E. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.

F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred ~~and Unreported~~ **but Not**

Reported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

3.3.6 Prohibited Claims

A. Contractor must comply with 22 CCR sections 53866, 53220, and 53222 regarding the submission and recovery of claims for services provided under this Contract. Contractor must ensure that its Subcontractors and Downstream Subcontractors also comply with 22 CCR sections 53866, 53220, and 53222.

B. Contractor must hold harmless and indemnify Members for Contractor's debt to Providers for services rendered and billed to Members.

3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider

A. Reimbursement of Non-Contracting Federally Qualified Health Centers (FQHCs) and Rural Health Center (RHCs)

If FQHC and RHC services are not available in Contractor’s Network in a particular county of Contractor’s Service Area, Contractor must reimburse non-contracting FQHCs and RHCs for Covered Services in that county provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

B. Required Terms and Conditions for Network Provider Agreements with FQHCs and RHCs

1) Contractor must submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for each of Contractor’s FQHC and RHC Network Provider Agreements.

2) Contractor must certify in writing to DHCS within 30 calendar days of DHCS’ written request that, pursuant to Welfare and Institutions Code (W&I) sections 14087.325(b) and (d), Contractor’s Network Provider Agreement terms and conditions with FQHCs and RHCs are the same as those offered to other Network Providers providing similar services, and that reimbursement is not less than the level and amount of payment which the entity would make for the

services if the services were furnished by a Provider which is not a FQHC or an RHC.

3) Contractor is not required to pay FQHCs and RHCs the Medi-Cal per-visit rate for that clinic.

4) Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.

5) Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325.

6) To the extent that an Indian Health Care Provider (IHCP) Facility ~~qualifies~~ **chooses to participate** as an FQHC or RHC, the above requirements in this Paragraph B must apply to a Network Provider Agreement with an IHCP. Moreover, Contractor must pay any non-contracted IHCP that qualifies as an FQHC or RHC an amount equal to what Contractor would pay a contracted FQHC or RHC, and DHCS must make any additional payment needed to comply with 42 CFR section 438.14(c).

7) Contractor or its Subcontractors and Downstream Subcontractors may enter into financial incentive payment arrangements with FQHC and RHC Network Providers provided such agreements meet all applicable conditions of federal and State law and of APL 19-005 including, but not limited to, the following:

    a) Contractor must establish and maintain clear, objective criteria for the financial incentive payments and the conditions under which payments will be made.

    b) The financial incentive payment arrangement must enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive payment.

    c) Contractor must have written agreements in place with the FQHC or RHC prior to the start of the financial incentive payment arrangement, including the methodology used to determine the total incentive payment amount.

    d) The financial incentive payments must be similar to, and not less in amount than, other financial incentive payments

Contractor makes to non-FQHC or non-RHC Network Providers who are providing similar services.

e) Financial incentive payment arrangements must not result in payments that are less than the payments made by Contractor to non-FQHC or non-RHC Network Providers who are providing similar services.

f) Contractor must evaluate the effectiveness of the financial incentive payments and adjust or discontinue them if they are determined ineffective upon evaluation.

g) Contractor must provide to DHCS, upon request, written agreements for, as well as policies and procedures for oversight and monitoring of, such financial incentive payments.

C. Indian Health Care Providers

1) Contractor must attempt to contract with each IHCP in its Service Area as set forth in 22 CCR sections 55120 - 55180. Contractor must reimburse an IHCP that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR section 438.14(c)(1).

2) For services provided to Members who are qualified to receive services from an IHCP pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHCP is a Network Provider:

a) Contractor must reimburse IHCP at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS) in accordance with APL 17-020 and APL 21-008.

b) Contractor must ensure compliance with any retroactive changes to the outpatient per visit rates published in the Federal Register by the IHS by appropriately reimbursing IHCPs in accordance therewith.

c) Contractor must reimburse IHCPs at the Medi-Cal Fee-For-Service (FFS) Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the IHS.

3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers

In accordance with 22 CCR section 51345 *et seq*. and APL 18-022, if there are no non-contracting Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Licensed Midwife (LM) Providers in Contractor's Network, Contractor must reimburse non-contracting CNMs, NPs, or LMs for services provided to Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Exhibit A, Attachment III, Subsection 3.3.16.A.3) (*Emergency Services*), if applicable, apply. For Free Standing Birthing Centers, Contractor must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, Contractor also must pay the Center's facility fee.

3.3.9 Non-Contracting Family Planning Providers

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

3.3.10 Sexually Transmitted Disease

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracted family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for the diagnosis and treatment of a Sexually Transmitted Disease (STD) episode, as defined in Policy Letter (PL) 96-09. Contractor must provide reimbursement only if the STD treatment Provider provides treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

3.3.11 Human Immunodeficiency Virus Testing and Counseling

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for Human Immunodeficiency Virus (HIV) testing and counseling in accordance with PL 97-08. Contractor must provide reimbursement only if such non-contracting family planning Providers make reasonable efforts to report confidential test results to Contractor in accordance with applicable laws and regulations, including but not limited to H&S section 121025 *et seq*.

3.3.12 Immunizations

Contractor must reimburse local health departments for the administration fee for immunizations given to Members, in accordance with the terms set forth in APL 18-004, who are not already immunized as of the date of the immunization. The local health department must provide immunization records when immunization services are billed to Contractor. Other than local health departments, Contractor is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with Contractor.

3.3.13 Community Based Adult Services

Contractor must reimburse Network Providers for Community Based Adult Services (CBAS) pursuant to a reimbursement structure that must include an all-inclusive per-Member, per-day of attendance rate, or otherwise be reflective of the acuity and/or level of care of the Member population served by Network Providers of CBAS. In accordance with W&I section 14184.201(d)(4), Contractor must reimburse Network Providers of CBAS the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan and other applicable guidance, including but not limited to guidance issued pursuant to W&I section

14184.102(d), unless Contractor and the Network Provider mutually agree to reimbursement in a different amount. Contractor may include incentive payment adjustments and performance and/or quality standards in its rate structure in paying Network Providers of CBAS.

3.3.14 Organ and Bone Marrow Transplants

In accordance with W&I section 14184.201(d), and for applicable dates of service, Contractor must reimburse a Provider furnishing organ or bone marrow transplant surgeries to a Member the amount the Provider could collect for those same services if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d).

3.3.15 Long-Term Care Services

In accordance with W&I sections 14184.201(b) and (c), and for applicable dates of service, Contractor must reimburse a Network Provider furnishing institutional Long-Term Care LTC services to a Member the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d). As used in this provision, “institutional LTC services” has the same meaning as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions and, subject to W&I section 141814.201(g), includes, at a minimum, all of the following services: Skilled Nursing Facility (SNF) services; subacute facility services; pediatric subacute facility services; and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services.

3.3.16 Emergency Services and Post-Stabilization Care Services

A. Emergency Services

1) Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a)(i) – (iii).

Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor.

2) Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers, Contractor, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3) Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor. Emergency Services must not be subject to Prior Authorization by Contractor.

4) At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5) For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in accordance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) above and 42 USC section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1) Except for the response time periods set forth in 42 CFR section 422.113(c)(2)(ii) and (iii)(A), Post-Stabilization Care Services must be covered by and paid for in accordance with 42 CFR section 422.113(c) and APL 23-009. Applicable response time periods involving Post-Stabilization Care Services is governed by Exhibit A, Attachment III, Subsection 2.3.2(B) (*Timeframes for Medical Authorization*) of this Contract and APL 23-009. Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are authorized by Contractor, Subcontractor, or Downstream Subcontractor.

2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or resolve the Member's stabilized condition if Contractor, Subcontractor, or Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, Subcontractor, or Downstream Subcontractor and the treating Provider cannot reach an agreement concerning the Member's care. In this situation, the treating Provider may continue with care of the Member until Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.

4) Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care; a Network Provider assumes responsibility for the Member's care through transfer; Contractor's Representative and the treating Provider reach an agreement concerning the Member's care; or the Member is discharged.

5) Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS Rate for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

   a) For the purposes of this Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), the FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I section 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

   b) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 must constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 must not have any effect on payments made by Contractor pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of W&I section 14454 and 22 CCR section 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Contractor agrees to implement DHCS' determination and reimburse the out-of-Network Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to

reimburse the out-of-Network Provider within 30 calendar days must result in capitation offsets in accordance with W&I sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Contractor to sanctions pursuant to W&I section 14197.7.

3.3.17 Provider-Preventable Conditions

Contractor, Subcontractor, or Downstream Subcontractor, or Network Provider must not pay any Provider claims nor reimburse a Provider for a Provider-Preventable Condition (PPC) in accordance with 42 CFR section 438.3(g). Contractor must report and require any and all of its Network Providers, Subcontractors, and Downstream Subcontractors to report PPCs in the form and frequency required by APL 17-009.

3.3.18 Prohibition Against Payment to Excluded Providers

In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of this Contract. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

Contractor must reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in Exhibit B, Section 1.14 (Special Contract Provisions Related to Payment). Contractor must provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in a form and manner specified by DHCS through APLs or other technical guidance.

Exhibit A, ATTACHMENT III

4.0 Member

DHCS is committed to ensuring that the Medi-Cal Member's experience is at the center of health care delivery from the point of Enrollment into a managed care plan throughout their time as a Member.

This Article makes explicit DHCS' commitment to a comprehensive population health managed approach that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, Complex Care Management (CCM), Transitional Care Services, and Enhanced Care Management (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying Members' risk on an individual basis, Contractors are required to have the systems (including data analytic capabilities), processes, and people (including ECM Providers in network with direct experience working with specific Populations of Focus) to support appropriate Population Health Management functions.

This Article also makes explicit DHCS' commitment to ensure that Members are appropriately accessing Covered Services, including when they are referred to community-based Providers. For example, Contractor must ensure referrals to services provided by Community Health Workers (CHWs), peer counselors, and local community organizations providing Community Support services.

This Article includes provisions that directly address Social Drivers of Health (SDOH) – from capturing and tracking SDOH data to providing Community Support services. Community Support services, such as medically tailored meals and short-term post-hospitalization services, are intended to address SDOH and can be provided by Contractors to the extent they are medically appropriate, cost-effective substitutes for Covered Services.

Finally, this Article outlines provisions related to Grievances and Appeals which includes processes by which Contractors must inform Members of their rights and ensure seamless processes by which Members can exercise their rights. DHCS also includes reporting requirements to enable DHCS to effectively monitor, oversee, and enforce Contract provisions when needed.

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

Before conducting any Marketing, Contractor must develop a training and certification program for Contractor's Marketing Representatives, and ensure that all staff performing any Marketing activities or distributing Marketing Materials are appropriately certified.

A. Contractor is responsible for all Marketing activities conducted on its behalf. Contractor is liable for all violations committed by any of its Marketing Representatives. Marketing staff must not provide Marketing services for more than one Contractor, and Marketing strategies must align with Contractor's efforts in improving Health Equity. Marketing Representatives must not engage in Marketing practices that illegally discriminate against a Member or Potential Member on the basis of any characteristic protected by federal or State law. Such protected characteristics include, without limitation, sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56. Contractor must ensure all Marketing activities and Marketing Materials are culturally and linguistically competent in compliance with Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) and Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Training Program

Contractor must develop a training program that will train staff and prepare Marketing Representatives for certification. Prior to implementation, Contractor must obtain written approval from DHCS for Contractor's training and certification program, and any changes in the program. Contractor must develop and provide to Marketing Representatives a staff orientation and Marketing Representative training/certification manual. At a minimum, the manual must explain:

1) The Medi-Cal program, including Medi-Cal Fee-For-Service (FFS), Medi-Cal managed care, Network Providers, Subcontractors, Downstream Subcontractors, and program eligibility;

2) The Medi-Cal scope of services;

3) Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of Member Enrollment, and aid categories;

4) Contractor's Utilization Management policy, including, but not limited to, how Members are obligated to obtain all Non-Emergency medical care through Contractor's Network and a description of all prerequisites to medical care and other health care services, such as referrals and Prior Authorizations;

5) Contractor's Grievance and Appeals procedures; the State Hearing process; and, as applicable to Contractor's plan model, the Independent Medical Review (IMR) process;

6) When Members can disenroll from Contractor, including qualifying conditions for both voluntary and mandatory disenrollment;

7) Contractor's obligation to keep confidential any information obtained from Members and Potential Members, including information regarding eligibility under any public welfare or social services program;

8) How Contractor will supervise and monitor its Marketing Representatives and staff to ensure compliance with applicable statutes and regulations;

9) The types of acceptable and prohibited communication methods and sales techniques Marketing Representatives may or may not use;

10) Contractor's anti-discrimination policy and the prohibition against the Enrollment or failure to enroll a Member or Potential Member due to a pre-existing medical condition (except for conditions requiring Excluded Services); and

11) The consequences of Marketing misrepresentation and Abuse, including, but not limited to, discipline, suspension of Marketing activities, termination, and civil and criminal prosecution. The Marketing Representative and Contractor must understand that any Abuse of Marketing requirements can result in termination of this Contract.

4.1.2 Marketing Plan

Before conducting any Marketing, or implementing any Marketing plan, Contractor must develop and obtain DHCS written approval for its Marketing plan or changes to a Marketing plan as specified below. The Marketing plan must be specific to the Medi-Cal program only and Marketing Materials must be distributed within Contractor's entire Service Area. Contractor must ensure that the Marketing plan and all related materials are accurate and do not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program.

A. Contractor must submit a Marketing plan to DHCS for review and approval on an annual basis and any time Contractor desires to change its Marketing plan. The Marketing plan, whether new or revised, must describe all of Contractor's current and proposed Marketing, including, but not limited to, all procedures, activities, events, and methods.

B. Contractor's Marketing plan must contain the following:

1) A table of contents section that divides the Marketing plan into chapters, sections, or pages. Each page must be dated and numbered so that chapters, sections, or pages can be easily identified and replaced when revised.

2) A mission statement or statement of purpose for the Marketing plan.

3) An organizational chart including key staff positions and the Marketing director's name, address, telephone, and facsimile number.

4) A narrative description explaining how Contractor's internal Marketing department operates by identifying key staff positions, roles, and responsibilities. The narrative must also report relationships including, if applicable, how Contractor's commercial Marketing staff and functions interface with Contractor's Medi-Cal Marketing staff and functions.

5) Copies of all Member incentives Contractor will distribute during any Marketing event or through any other Marketing activities, in accordance with All Plan Letter (APL) 16-005.

6) An explicit description of all of Contractor's expected Marketing methods and activities.

7) Documentation of all agreements between Contractor and the organizations with which it is undertaking Marketing activities.

8) All Marketing Materials Contractor will use, including those for English-speaking populations, non-English speaking populations, and alternative formats for people with disabilities (including Braille, large-size print font no smaller than 20-point, accessible electronic format, and audio format).

9) A description of the methods Contractor will use to distribute Marketing Materials in compliance with APLs, this Contract, and State and federal law, including, but not limited to, the Telephone Consumer Protection Act of 1991 (47 United States Code (USC) section 227).

10) Copies of a sample Marketing identification badge and business card clearly identifying Marketing Representatives as Contractor's employees. Marketing identification badges and business cards must not resemble those of a government agency.

11) Written formal procedures for monitoring the performance of Contractor's Marketing Representatives to ensure Marketing integrity, pursuant to Welfare and Institutions Code (W&I) section 14408(c).

12) All sites for proposed Marketing activities, such as annual health fairs and community events in which Contractor proposes to participate.

13) All other information requested by DHCS to assess Contractor's Marketing program.

C. If Contractor wishes to conduct a Marketing activity not included in the approved Marketing plan, Contractor must submit a written request and obtain prior written approval for that Marketing activity from DHCS. Contractor must submit the written request, a copy of the proposed Marketing Materials, and all other required documentation at least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.

D. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must notify its designated DHCS Contract Manager in writing and provide required documentation for DHCS review and approval. In cases where Contractor learns of a

Marketing event less than 30 calendar days before the event, Contractor must immediately provide written notification and required documentation to DHCS for review and approval. In no instance may notification be less than two Working Days before the Marketing event.

E. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must submit a community event Marketing agreement for DHCS review and approval. Along with the community event Marketing agreement, there must be an attestation from the event organization stating that:

1) Contractor will not distribute Marketing Materials or conduct Marketing presentations at a Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider site, including hospitals and their property; and

2) There are trained Marketing staff at the Marketing event and, if the Marketing event is educational, there are trained health educators at the Marketing event.

F. Contractor must obtain prior DHCS approval before performing in-home Marketing presentations and must provide strict accountability, including documentation from the Potential Member requesting an in-home Marketing presentation or a telephone log entry documenting the Potential Member's request.

G. Contractor must submit any advertisement intended for Marketing purposes to DHCS for prior approval. Such advertisements include, but are not limited to, mass media, magazines, newspapers, radio, telephonic Marketing, TV, billboards, bus sides, and any mobile advertisements.

H. Contractor must not position any mobile advertisements at any Network Provider, Subcontractor, Downstream Subcontractor, or non-contracted Provider sites, including hospitals and their property.

I. When conducting Marketing, Contractor must comply with W&I sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411 and 22 California Code of Regulations (CCR) sections 53880 and 53881.

J. Contractor must not engage in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing for the purpose of enrolling Potential Members, or for any other purpose.

K. Contractor must not distribute Marketing Materials or conduct Marketing presentations at any Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider sites, including hospitals and their property.

L. Contractor must not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

M. Contractor's Marketing Materials must not contain any statements that suggest Enrollment is necessary to obtain or to avoid losing Medi-Cal benefits, or that Contractor is endorsed by DHCS, Center for Medicare & Medicaid Services (CMS), or any other State or federal government entity.

N. All of Contractor's Marketing must be accurate and not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program, pursuant to 42 Code of Federal Regulations (CFR) section 438.104.

Exhibit A, ATTACHMENT III

4.2 Enrollments and Disenrollments

4.2.1 Enrollment
4.2.2 Disenrollment

4.2 Enrollments and Disenrollments

4.2.1 Enrollment

Contractor must cooperate with the DHCS Enrollment processes and the DHCS Enrollment contractor in enrolling all Potential Members into Medi-Cal managed care health plans. DHCS and its Enrollment contractor will verify eligibility status and notify the Potential Member of the available Medi-Cal managed care health plans in their County. Contractor must ensure mandatory and voluntary Potential Members residing in its Service Area, are properly enrolled pursuant to the requirements of this provision.

A. Non-Discrimination in Enrollment

Contractor must accept as Members all Potential Members who select or are assigned to Contractor without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, pre-existing medical condition(s), genetic information, health status, marital status, gender, gender identity, sexual orientation, existing or prior involvement in the justice system, or identification with any other persons or groups defined in California Penal Code section 422.56.

B. Enrollment Processing Criteria

1) Contractor must accept as Members all Potential **Members** who meet the Enrollment criteria in 22 California Code of Regulations (CCR) section 53845, as follows:

a) Potential Members with a Mandatory ~~Aid Code~~ **aid code** unless they qualify for an exemption from Enrollment pursuant to 22 CCR section 53887 or meet the criteria in 22 CCR section 53891(c).

b) Potential Members with a Mandatory ~~Aid~~ **aid** code who are default enrolled because they did not select a Medi-Cal managed care plan during the choice timeframe.

c) Potential Members with a Justice Involved aid code who are default enrolled per the Justice Involved Reentry Initiative, as described in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

~~c~~**d**) Potential Members with a Voluntary ~~Aid~~ **aid** code who select Contractor as their Medi-Cal managed care plan.

C. Enrollment Process

1) Contractor will receive an effective Enrollment date from DHCS that is no later than 90 calendar days from the date that Medi-Cal Eligibility Data System (MEDS) lists the individual as meeting the required Enrollment criteria contained in 22 CCR section 53845(a).

2) DHCS or its Enrollment contractor will assign Potential Members meeting the Enrollment criteria contained in 22 CCR section 53845(a) to Medi-Cal Managed Care Health Plans in accordance with 22 CCR section 53884, if the Potential Member fails to select a plan after receiving notice that they are required to enroll in Medi-Cal Managed Care.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above do not apply to Potential Members without a current valid deliverable address or with an address designated as a county post office box for homeless Members.

D. Enrollment Disputes

1) Contractor must notify DHCS of Enrollment disputes, pursuant to the requirements and procedures contained in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*).

2) DHCS has 120 calendar days from the date of DHCS' receipt of Contractor's Enrollment dispute notice (the "cure period") to make necessary Enrollment corrections or adjustments, identified in Contractor's dispute notice, without incurring any financial liability to Contractor. For purposes of this Provision, DHCS will be deemed to have corrected or adjusted any issues identified in Contractor's notice if, within the cure period, any of the following occurs:

a) Mandatory plan Members receive an effective Member Assignment date that is within the cure period; or

b) DHCS corrects or adjusts an Enrollment issue by redirecting Enrollment from Contractor to another Contractor within the cure period; or

c) Within the cure period, DHCS changes the distribution of Member Assignment, subject to the requirements of 22 CCR section 53845, to the maximum extent new Members are available to be assigned, to adjust for the number of incorrectly assigned Members.

3) If it is necessary to redirect Enrollment or change the distribution of Member Assignment and such change varies from the requirements of 22 CCR section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with 22 CCR sections 53884(b)(5) or (b)(6) after any necessary Enrollment correction or adjustment.

4) DHCS will not be financially liable to Contractor for any Enrollment dispute, in an affected county (on a county-by-county basis) if Contractor's loss of mandatory plan Members, in a month in which a dispute occurs, is less than 5 percent of Contractor's total Members in that affected county. The parties acknowledge that the above referenced 5 percent threshold will apply on a county-by-county basis, not in the aggregate. DHCS' financial liability must not exceed 15 percent of Contractor's monthly Capitation Payment.

E. Coverage

1) Member coverage begins at 12:01 a.m. on the first day of the calendar month for which the Potential Member's name is included on the list of new Members assigned to Contractor. The term of Enrollment continues indefinitely until this Contract expires, is terminated, or the Member is disenrolled pursuant to the conditions described in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) below.

2) Contractor must authorize and provide coverage for Medically Necessary Covered Services to a Child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn Child for month of birth and the month following birth.

F. Temporary Exemption from Mandatory Enrollment

A Member in a mandatory aid code category who currently has a DHCS approved medical exemption request pursuant to 22 CCR section 53887

will not be assigned to Contractor until the medical exemption expires or the medical exemption is subsequently denied by DHCS.

G. Mandatory Assignment Restrictions

Assignment will continue on a monthly basis unless restricted by DHCS. DHCS will impose assignment restrictions and provide written notice to Contractor at least ten calendar days prior to the start of the restriction period. DHCS will notify Contractor at least ten calendar days before the end of the restriction period.

4.2.2 Disenrollment

DHCS or its agent will process a Member's disenrollment from Contractor under the following conditions, in accordance with the provisions of 22 CCR section 53891:

A. Disenrollment from Contractor is mandatory when:

1) The Member requests disenrollment with a request for Enrollment in the competing Medi-Cal managed care plan pursuant to 22 CCR section 53891(c), subject to any lock in restrictions on disenrollment under the federal lock in option, if applicable, or when the Member enrolls in a Medicare Advantage plan that is affiliated with a competing Medi-Cal managed care plan.

2) The Member is no longer eligible for Enrollment with Contractor because they lost Medi-Cal eligibility, including the death of a Member.

3) Contractor's contract is terminated or Contractor no longer participates in the Medi-Cal Program.

4) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing.

5) The Member requests disenrollment in accordance with Welfare and Institutions Code (W&I) section 14303.1, following a merger with other organizations, or W&I section 14303.2, following a reorganization or merger, with a parent or subsidiary corporation. In these circumstances, Contractor must give Members the option to disenroll for any cause, and request Enrollment in another Medi-Cal managed care plan within 60 calendar days following the date of

the reorganization or merger. Contractor must not disenroll the Member to Fee-For-Service(FFS).

6) A Member's change of residence is outside of Contractor's Service Area.

Mandatory disenrollment from Contractor will be effective on the first day of the next month after DHCS receives all documentation it determines are necessary to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in above Paragraph A.6) of this Subsection, Enrollment terminates no later than midnight on the last day of the first calendar month after DHCS receives the Member's disenrollment request and all required supporting documentation for Enrollment in a competing plan. On the first day after Enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for Members no longer enrolled with Contractor under this Contract.

C. Contractor must implement and maintain procedures to ensure that all Members requesting disenrollment are provided an explanation of the Member's right to disenroll at any time, with the requirement that the Member enroll in the competing Medi-Cal managed care plan in the county, subject to the requirements in 22 CCR section 53891(c), and any restricted disenrollment period. Additionally, Contractor must immediately refer Members requesting disenrollment from Contractor to the DHCS Enrollment contractor so the Member may be enrolled in another Medi-Cal managed care plan or disenrolled because they require a carved-out service.

Exhibit A, ATTACHMENT III

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements
4.3.2 Population Needs Assessment
4.3.3 Data Integration and Exchange
4.3.4 Population Health Management Service
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
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4.3.10 Transitional Care Services
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4.3.12 Mental Health Services
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4.3.19 Women, Infants, and Children Supplemental Nutrition Program
4.3.20 Home and Community-Based Services Programs
4.3.21 In-Home Supportive Services
4.3.22 Indian Health Care Providers
4.3.23 ~~Managed Care Liaisons~~ **Justice Involved Reentry Coordination**
4.3.24 Managed Care Liaisons

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess ~~each~~ Member~~'s~~ needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes **at both the individual Member level, and at the community level**. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024.

B. Contractor must ensure its PHM program meets**, at a minimum,** all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. ~~Contractor must conduct a Population Needs Assessment (PNA) as described in Subsection 4.3.2 (*Population Needs Assessment*) and submit a Population Health Management Strategy (PHMS) to DHCS for approval that details all components of its PHM program activities in accordance with the requirements of this Section and the DHCS Comprehensive Quality Strategy. Contractor must engage Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs) and other stakeholders identified in Subsection 4.3.2 (*Population Needs Assessment*) to develop its PNA and PHMS and when developing new initiatives.~~ **As described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*) and in accordance with APL 23-021, Contractor must fulfill its Population Needs Assessment (PNA) requirement by meaningfully participating in the local health jurisdiction (LHJ) Community Health Assessment (CHA)/ Community Health Implementation Plan (CHIP) process in the Service Area county(ies) in which it operates, and submit a PHM Strategy, informed by PNA findings, to DHCS. PHM Strategy submission documentation will include an NCQA-approved PHM strategy for accredited Plans. Contractor that has not yet obtained NCQA accreditation is still responsible for submitting PHM Strategy documentation prepared for near-future NCQA submission in line with NCQA Health Plan Accreditation standards, inclusive of population assessment documentation informing PHM Strategy and**

accreditation application process if Contractor is without current accreditation, upon DHCS request,

4.3.2 Population Needs Assessment

~~In accordance with 42 Code of Federal Regulations (CFR) sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2), 22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53904(a)(3), and 53910.5(a)(2), and applicable DHCS guidanceContractor must conduct a~~ Population Needs Assessment (PNA) at least ~~every three years in partnership with key stakeholders, including but not limited to local delivery systems, health departments, hospital associations/organizations, and in alignment with requirements held by NCQA population health standards. Contractor must use the PNA to identify population-level health and social needs, including Health Disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor must implement Health Equity, health education, and continuous Quality Improvement (QI) programs and services, and determine relevant subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:~~

~~A. Contractor's PNA must evaluate, at a minimum, the following factors for its entire Member population:~~

~~1) General characteristics and health needs;~~

~~2) Health status, behaviors and utilization trends, including use of Emergency Services;~~

~~3) Health education, and cultural and linguistic needs;~~

~~4) Health Disparities;~~

~~5) Social Drivers of Health (SDOH); and~~

~~6) Any gaps in services and resources even if they are not Covered Services under this contract.~~

~~B. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:~~

~~1) Data from Subcontractors and Downstream Subcontractors; and~~

~~2) Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.~~

~~C. Contractor must use reliable data sources, including Subcontractor and Downstream Subcontractor level data, to conduct and update the PNA at least every three years. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.~~

~~D. In order to assess Member needs in Contractor's Service Area, Contractor must engage representatives of LHDs, LEAs, LGAs, Safety Net Providers, community based organizations, County Mental Health Plans (MHPs), Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans, community mental health programs, (Primary Care Provider (PCPs), social service Providers, Regional Centers (RC), California Department of Corrections and Rehabilitation, county jails and juvenile facilities, Child welfare agencies as well as stakeholders from special needs groups, including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.~~

~~E. Contractor must provide a report on the PNA to its Community Advisory Committee (CAC). Contractor must have a process to obtain input, advice, and recommendations on the PNA from its CAC.~~

~~F. Based on the PNA, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:~~

~~1) Targeted health education materials for Members;~~

~~2) Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-specialty Mental Health Services;~~

~~3) Cultural and linguistic, and QI strategies to address identified population-level health and social needs; and~~

~~4) Wellness and prevention programs.~~

~~G. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.~~

A. Contractor must conduct a PNA by participating in the CHA/ CHIP processes led by Local Health Departments (LHDs) in the Service Area county(ies) where Contractor operates, as defined further in APL 23-021 and the PHM Policy Guide.

B. Contractor operating in multiple LHD jurisdictions must participate in the CHA/CHIP process for each jurisdiction in which it operates.

C. Contractor must submit an annual PHM Strategy that demonstrates that Contractor is responding to community needs and provides PHM updates as specified and, in the format prescribed by the Department.

D. Contractor must ensure that any populations covered by a Fully Delegated Subcontractor, Partially Delegated Subcontractor, or Downstream Subcontractor are included in the PNA and PHM Strategy process.

E. Contractor must publish on its website all LHD CHAs/CHIPs in the Service Area along with a brief description of how Contractor participated in the CHA/CHIP process. Contractor must also share findings from the CHA/CHIPs in Service Area with their Community Advisory Committees (CACs).

F. Based on participation in the CHA/CHIP process in the Service Area, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

1) Targeted health education materials for Members, including Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services;

2) Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and

3) Wellness and prevention programs.

G. Contractor's MOU with an LHD must include a requirement that Contractor coordinate with the LHD to develop a process to implement DHCS guidance regarding the PNA and PHM Strategy requirements.

H. **The PNA and PHM Strategy requirements, as outlined in this Subsection, and other PHM deliverables, as described in this Contract, remain consistent with 22 CCR, sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), 28 CCR, section 1300.67.04; 42 CFR sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2); and APL 23-021.**

I. **Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated to Contractor via the PHM Policy Guide.**

4.3.3 Data Integration and Exchange

In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code (H&S) section 130290.

F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F

4.3.4 Population Health Management Service

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to:

A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection;

B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide ;

C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

A. Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below:

1) Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH;

2) Comply with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a Significant Change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification;

5) Incorporate a minimum list of data sources, as specified in the PHM Policy Guide;

6) Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and

7) Continuously reassess the effectiveness of the RSS methodologies and tools.

B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to:

1) Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic PHM, and Transitional Care Services; and

2) Contractor may supplement the PHM Service outputs with local data sources and methodologies

C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS.

4.3.6 Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact

a Member to conduct the initial screening or assessment using available modalities.

B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required assessments are completed per the specifications above.

4.3.7 Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving **the** care management **services described in this Subsection** must have an assigned CCM Care Manager and a Care Management Plan (CMP).

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members**. ECM provides** ~~through~~ systematic coordination of services and ~~consistently apply~~ comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

Complex Care Management

Complex Care Management (CCM) (which equates to "Complex Case Management" as defined by NCQA) is an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members through both ongoing, chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. ~~all eligible~~ Members have the right to participate or to decline to participate.

Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members, **at minimum**. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

A. Care Management Programs

Contractor must operate and administer the following care management programs:

1) ECM as described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

2) CCM

a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

i. Contractor's CCM program must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

ii. Contractor's CCM program must include comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up;

iii. Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate;

iv. Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic Care Coordination and interventions for episodic, temporary needs;

v. Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.

vi. **For Members under age 21,** Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal-services.

b) Contractor must assess Members for the need for Community Supports as part of its CCM program~~.and provide Community Supports if medically appropriate and cost effective~~ **to eligible Members**.

c) A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.

B. CCM Care Manager Role

1) Assignment of CCM Care Manager

a) Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. **Following NCQA requirements, Contractor may delegate CCM to Network Providers or other entities that are NCQA-certified.** PCPs may be assigned as CCM Care Managers when they are

able to meet all the requirements specified in this Subsection.

b) When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide the Member's PCP with the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) CCM Care Manager Responsibilities

a) Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards.

b) Contractor must ensure that the CCM Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (ARs), caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Provide referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS,

Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a MOU;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

4.3.8 Basic Population Health Management

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with Contractor;

4) Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers;

6) Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU;

7) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

8) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

9) Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members;

10) Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor’s Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members’ needs and to mitigate impacts of SDOH;

11) Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for Memorandums of Understanding (MOUs) in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*);

12) Assist Members, Members’ parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor’s

Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

13) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

14) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

15) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law;

16) Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, **including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290,** specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

17) Maintain processes to ensure no duplication of services occurs.

B. Wellness and Prevention Programs

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

3) Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

a) Identification of specific, proactive wellness initiatives and programs that address Member needs ~~as identified in the PNA~~;

b) Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs;

c) Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

d) Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

e) Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5 (*Services for Adults*) and in compliance with all applicable State and federal laws;

f) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);

g) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*); and

h) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

4) Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

5) Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA

is used to design and implement evidence-based wellness and prevention strategies.

4.3.9 Other Population Health Requirements for Children

For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities

Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 United States Code (USC) sections 1396d(a), 1396d(r), and 1396n(g)(2), and Welfare and Institutions Code (W&I) section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years of age, as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children with Special Health Care Needs

Contractor must develop and implement policies and procedures to provide services for CSHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.

2) Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CSHCN.

3) Methods for ensuring Care Coordination with Department of

Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the CCS Program.

C. Early Intervention Services

Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

4.3.10 Transitional Care Services

Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, **APL 22-024,** and ~~DHCS guidance~~ **the PHM Policy Guide**. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

Contractor must identify every Member undergoing a transition as high-risk or lower-risk according to the criteria in the PHM Policy Guide.

~~If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned Care Manager provides all Transitional Care Services.~~ **For all identified high-risk Members, Contractor must ensure a Member has a single point of contact for the duration of the transition.** If ~~the~~ **a** Member **identified as high risk** is not receiving CCM or ECM, ~~Contractor's Basic PHM staff are required to provide~~ **Contractor must identify a care manager who is a single point of contact responsible for** **ensuring the completion of** all Transitional Care Services, including making referrals and ensuring no gaps in care. **For Members identified as lower risk, a single point of contact is not**

required, but there must be a dedicated care management team available, as described further in the PHM Policy Guide.

Contractor must ensure that TCS processes meet the requirements of A-C below, for both high and lower risk Members. The PHM Policy Guide describes in further detail how the requirements below apply to high and lower risk Members.

Additional guidance is forthcoming on the specific TCS requirements for different populations.

A. **General Requirements for** Transitional Care **Applicable to All Members in Transition, including High- and Lower-Risk Members**

Contractor must implement transitional care processes that meet the following **further** requirements **as specified in the PHM Policy Guide**, at minimum:

1) **Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs;** ~~Implement a standardized discharge risk assessment that is to be completed prior to discharge to be approved by DHCS, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or SUD relapse;~~

2) ~~Obtain~~**Ensure that** permission **is obtained** from Members, Members' parents, legal guardians, or ARs, as appropriate to share information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations;

~~3) Ensure that medication reconciliation is conducted pre- and post-transition;~~

~~4~~ **3**) Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) **for Members who may be eligible for such services, and in accordance with any MOU executed between Contractor and such agencies;**

4) Ensure referrals to ECM and Community Supports for Members identified as having unstable housing, experiencing

homelessness, or needing nursing facility care, for whom transition to home/assisted living facility or short term post hospitalization/recuperative care are alternatives;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*). **Prior Authorizations should be complete prior to discharge.** This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) ~~Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs~~ **Require all of its contracted hospitals, and all SNFs with electronic health records, to send Admission, Discharge, and Transfer (ADT) notifications to Contractor for each of its assigned Members in accordance with Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290, and as further specified in the PHM Policy Guide**; and

10) Ensure **all** Members ~~with SUD and mental health needs receive treatment for those conditions upon discharge~~ **being discharged from discharging facilities, including SNFs, have a PCP who can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs**.

B. **Responsibility to Ensure Completion of Facility's** Discharge Planning ~~and Coordination~~ **Process, Including Member Engagement for All Members, Including Both High and Lower Risk Members.**

Contractor must ~~provide a~~ **ensure the discharging facility completes a** Discharge Planning ~~document to~~ **process that engages** Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged from a hospital, institution or facility. ~~Contractor's Discharge Planning document must include the following information, at a minimum~~ **Contractor must ensure that the facility's process is consistent with CMS Conditions of Participation, State regulations, and Joint Commission Requirements, as applicable, including as follows**:

1) ~~Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;~~**Contractor must ensure the discharging facility focuses on the Member's goals and treatment preferences during the discharge process, and that they are documented in the Medical Record. Contractor must ensure the discharging facility uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.**

   a) For high-risk Members, Contractor must ensure the facility shares this information with the care manager. Contractor must also ensure the discharging facility has processes and procedures in place to refer Members to ECM or Community Supports as needed.

   b) For lower risk Members, Contractor must ensure the hospital has processes and procedures to leverage this assessment to identify Members who may benefit from services and refer Members to Contractor for high risk TCS, ECM, or Community Supports.

2) ~~Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;~~ **For discharge instructions, Contractor must ensure that the Member and their designated caregiver are informed of the continuing health care requirements following discharge from the facility. This information must include, but is not limited to, education and counseling about the Member's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally and linguistically appropriate format to the Member and caregiver, and must include the opportunity for the caregiver to ask questions about the post-hospital needs of the Member per H & S section 1262.5.**

3) ~~The hospital, institution or facility to which the Member was admitted;~~ **For discharge coordination, Contractor must ensure discharging facility has process in place for coordinating care with the following:**

a) For Member's designated family caregiver, Contractor must ensure the discharging facility has processes to ensure Member's designated family caregiver is notified of the Member's discharge or transfer to another facility per H&S section 1262.5.

b) For post-discharge Providers, Contractor must ensure discharging facility provides necessary clinical information to the appropriate post-discharge Providers, including the discharge summary per 42 CFR section 482.43.

C. Transitional Care Services for High and Lower Risk Members

1) Contractor must identify every Member undergoing a transition as high risk or lower-risk. For the criteria for high and lower-risk, and detailed requirements for each, refer to the PHM Policy Guide.

2) For Members identified as high risk, Contractor must ensure the Member has a single point of contact for the duration of the transition who is responsible for ensuring a successful transition. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned care manager

provides all TCS. The single point of contact is responsible for:

a) **Outreach to Member;**

b) **Assessing Member's risk for adverse outcomes to inform needed TCS and identify Members that may require ECM, CCM (if not already enrolled), or Community Supports, using the discharging facility data and Member engagement;**

c) **Reviewing facility discharge summary;**

d) **Ensuring Member receives appropriate discharge instructions;**

e) **Ensuring follow up Providers receive appropriate clinical information;**

f) **Ensuring medication reconciliation is complete post discharge;**

g) **Ensuring Members with SUD and mental health needs receive treatment for those conditions upon discharge.**

h) **Ensuring the completion of all recommended follow-up, including any needed specialty or primary care follow-up, any SUD or mental health treatment, or any needed community or home-based services.**

3) **For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above:**

a) **Ensure Member has, at minimum, telephonic access to a dedicated TCS team for at least 30 days from the discharge. The team must:**

i. **Be able to access the Member's discharge documents to be able to assist Member with questions, including but not limited to medication changes;**

ii. **Assist Member with any TCS needs identified by**

Member, including but not limited to access to ambulatory care, appointment scheduling, referrals, arranging Non-Emergency Medical Transport (NEMT);

iii. Provide escalation to meet any TCS needs as needed, including connecting Members with a licensed Provider, if necessary; and

iv. Place and coordinate referrals to longer term care management programs such as ECM/CCM, and/or Community Supports for eligible Members at any point in the transition.

b) Ensure Member can access the TCS team through a dedicated phone number as follows:

i. During business hours, Contractor must ensure Members can connect with live TCS team member within no more than one automated phone selection option.

ii. Outside of business hours, Members must be able to be referred to Emergency Services as needed and be able to leave a message. TCS team must respond to Members within one Working Day of message.

iii. Contractor must ensure the Member is notified of the TCS support team and phone line directly, and make best efforts to ensure Member is notified directly within 24 hours of discharge.

c) Ensure Member completes follow-up with ambulatory PCP, Specialist, or advanced practice Provider that has prescribing authority within 30 calendar days to ensure medication reconciliation. For a Member who has not had a visit with their assigned PCP within the last 12 months, ensure the Member completes PCP follow-up in addition to any necessary non-primary care ambulatory visits within 30 calendar days.

d) Use data from discharges to assess and identify Members that may newly qualify for ECM/CCM or

Community Supports.

4) ~~Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;~~

5) ~~Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or ARs in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record; and~~

6) ~~Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.~~

~~C~~**D**. Nursing Facility Transitions

1) **For diversion from the need for a nursing facility with supports, Contractor must evaluate all Members who have been identified as requiring nursing facility care for Community Supports. This includes the following, as appropriate: short term post-hospitalization, recuperative care, and respite services; day habilitation services; Community Supports supporting transitions to home, or a Residential Care Facility for the Elderly/ Adult Residential Facility, and personal care/homemaker services; as well as for ECM, IHSS, and/or waiver programs that may allow the Member to live at home or in alternative settings with support, as aligned with the Member's goals.**

2) When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

~~1~~ **a**) Coordinate with facility discharge planners, care or Case Managers, or social workers to provide case management and Transitional Care Services during all transitions;

~~2~~ **b**) Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs;

~~3~~ **c**) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

d) Ensure all Members being discharged from nursing facilities, have a PCP that can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs.

~~4~~**e**) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

~~5~~ **f**) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

~~6~~ **g**) Follow-up with Members, Members' parents, legal guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

4.3.11 Targeted Case Management Services

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services. **For specific guidance on ECM overlap with county-based TCM, see the ECM Policy Guide.**

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age)*. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

4.3.12 Mental Health Services

Contractor must use DHCS-approved standardized screening tools as identified in APL 22-028 to ensure Members seeking mental health services who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

A. Non-specialty Mental Health Services

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when:

1) NSMHS were provided:

    a) During the assessment process;

    b) Prior to determination of a diagnosis; or

    c) Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;

2) NSMHS were not included in a Member's individual treatment plan;

3) Member has a co-occurring mental health condition and SUD; or

4) NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.

B. Specialty Mental Health Services

1) Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.

2) Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner.

3) If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

C. Mental Health Services Disputes

1) Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP.

2) If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute.

3) Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP.

4.3.13 Alcohol and Substance Use Disorder Treatment Services

A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area.

B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.

C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member.

D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.

E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms **that align with DHCS data sharing and authorization guidance** for the disclosure of information that provide the following:

1) Comply with 42 CFR part 2;

2) Name both Contractor and DHCS as potential recipients of the data being disclosed;

3) Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by HIPAA; and

4) If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

4.3.14 California Children's Services

A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in COHS counties, Contractor must maintain

policies and procedures to identify and refer Members with California Children's Services (CCS)-Eligible Conditions to the local CCS Program for determination of CCS eligibility. These policies and procedures must include the following, at a minimum:

1) The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-Eligible Condition;

2) The requirement that Contractor supports CCS program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS program through internal reports, Provider directed referrals, or direct referrals from Contractor.

3) Instruct Network Providers that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network, and that reimbursement is only from the date of referral;

4) The requirement that Network Providers complete the initial referrals of Members with suspected CCS-Eligible Conditions same day using modalities accepted by the local CCS Program. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program;

5) Instruct Network Providers of their requirement to continue to provide all Covered Services to the Member until CCS Program eligibility is confirmed;

6) The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the local CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012; and

7) The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the local CCS Program does not approve CCS Program eligibility. If the local CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the cost of the service if it is determined to be Medically Necessary.

B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the CCS Program about the Member.

C. Contractor must maintain policies and procedures for identifying CCS-eligible Members that are aging out of the CCS Program. Within 12 months of a CCS Member aging out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member's CCS-Eligible Condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition,

4) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS-Eligible Condition(s); and

5) Continued assessment of the Member through first 12 months of the transition.

D. Contractor must have Memorandums of Understanding (MOUs) with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.

4.3.15 Services for Persons with Developmental Disabilities

A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive.

B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).

C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to coordinate services for the Member with RC staff to ensure the non-duplication services and to create the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT).

D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS).

E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.

4.3.16 School-Based Services

A. Contractor must have an MOU in place with all LEAs in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule Contractor must execute agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).

C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers

D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).

4.3.17 Dental

A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.

B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member’s first tooth or at 12 months of age, whichever occurs first.

C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to laboratory services, and pre-admission physical

examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures.

If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB):

1) Members with demonstrated resistance to Isoniazid and Rifampin;

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Substance users;

4) Members with mental health conditions or SUD;

5) Elderly, Children and adolescent Members;

6) Members with unmet housing needs;

7) Members with language and/or cultural barriers; and

8) Members who have demonstrated noncompliance by failing to keep office appointments.

B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.

C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on DOT.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

A. Women, Infants, and Children (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record.

B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

4.3.20 Home and Community-Based Services Programs

A. DHCS administers, either directly or through another State entity, a number of Medi-Cal Home and Community-Based Services (HCBS) programs authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible Members in the community setting of their choice instead of in an institution.

B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and

medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health (CDPH), and the California Department of Aging;

3) Home and Community Based Alternatives Waiver agencies;

4) Assisted Living Waiver Care Coordination agencies;

5) RCs;

6) Multipurpose Senior Services Program sites;

7) Medi-Cal Waiver Program agencies; and

8) California Community Transitions lead organizations.

C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to provide all services and benefits covered under this Contract to the Member.

D. Contractor's collaboration with third-party entities providing the Member with HCBS program services or administering a HCBS program pursuant to the third-party entity's contractual or legal authority to administer HCBS

programs and/or provide HCBS program services to the Member, must include, but is not limited to:

1) Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns.

2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.

3) As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with one another, including PHI/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4.3.21 In-Home Supportive Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Designate a person to serve, as the day-to-day IHSS liaison with county IHSS agency.

1) Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for Members in inpatient and Skilled Nursing Facility settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

2) The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison.

D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

4.3.22 Indian Health Care Providers

Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

4.3.23 ~~Managed Care Liaisons~~ Justice Involved Reentry Coordination

Contractor must maintain policies and procedures for coordinating with Correctional Facilities and pre-release care managers in order to support Members who are leaving a Correctional Facility and reentering the community. Such policies and procedures must include all requirements as

detailed in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Initiative, including:

A. A designated Justice Involved liaison, as required in Exhibit A, Attachment III, Subsection 4.3.24 (*Managed Care Liaisons*);

B. Assigning ECM Providers to serve as pre-release care managers and/or as post-release ECM Providers for Justice Involved Individuals;

C. Coordinating the Member's transition from the pre-release to the post-release period, including any needed data sharing; and

D. Ensuring the provision of any Medically Necessary Covered Services including ECM, physical and behavioral health services, Community Supports, NEMT, and Non-Medical Transportation (NMT).

4.3.24 Managed Care Liaisons

Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services.

Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons:

A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*)

B. Long-Term Services and Supports (LTSS) Liaison

LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions,

policies and procedures; and care management, coordination and transition policies.

C. Transportation Liaison

Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive.

D. California Children's Services Liaison

CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children.

E. ~~Foster Care~~ **County Child Welfare** Liaison

1) Contractor must designate at least one individual to serve as the ~~foster care~~ **county child welfare** liaison **who will serve as a leader within Contractor to be the point of contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare**. Additional ~~foster care~~**county child** liaisons must be designated as needed to ensure the needs of Members involved with ~~foster care~~**county child welfare** are met.

2) Contractor's ~~foster care~~ **county child welfare** liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's ~~foster care~~**county child welfare** liaison must:

a) Have expertise in Child welfare services, County Behavioral Health Services.

b) Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with

other services, including social services and Specialty Mental Health Care Services.

c) ~~Oversee the~~**Act as a resource to** ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners.

d) Be sufficiently trained on County Care Coordination and assessment processes.

e) ~~Coordinate with foster care liaisons for other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans.~~**Provide resources and support to Member's care manager about Medi-Cal managed care plan Enrollment and disenrollment when they are made aware that the Member will move to a different county.**

~~f) Must also serve as a family advocate.~~

F. Justice Involved Liaison

1) **Contractor must have an assigned Justice Involved liaison for justice involved reentry coordination, which may be one individual or multiple identified individuals, and make available information related to the Justice Involved liaison's title, name, contact phone number and email address.**

2) **The Justice Involved liaison must be available to support Correctional Facilities, pre-release care management Providers, and/or ECM Providers in the reentry planning process as required in Exhibit A, Attachment III, Subsection 4.3.23 (*Justice Involved Reentry Coordination)* and further specified in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative.**

~~F~~**G.** RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (*Services for Persons with Developmental Disabilities*)

~~G~~**H.** Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*)

~~H~~**I.** IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Support Services*)

Exhibit A, ATTACHMENT III

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management
4.4.2 Populations of Focus for Enhanced Care Management
4.4.3 Enhanced Care Management Providers
4.4.4 Enhanced Care Management Provider Capacity
4.4.5 Enhanced Care Management Model of Care
4.4.6 Member Identification for Enhanced Care Management
4.4.7 Authorizing Members for Enhanced Care Management
4.4.8 Assignment to an Enhanced Care Management Provider
4.4.9 Initiating Delivery of Enhanced Care Management
4.4.10 Discontinuation of Enhanced Care Management
4.4.11 Core Service Components of Enhanced Care Management
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management
4.4.13 Oversight of Enhanced Care Management Providers
4.4.14 Payment of Enhanced Care Management Providers
4.4.15 Enhanced Care Management Reporting Requirements
4.4.16 Enhanced Care Management Quality and Performance Incentive Program

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management

A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide, in addition to provisions outlined in this Contract.

B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*), through systematic coordination of services and comprehensive care management.

C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

D. Contractor must ensure ECM is available throughout its Service Area.

E. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent.

F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor**,** ~~especially~~ **specifically** that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers.

G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III,

Subsection 4.4.11 (*Core Service Components of Enhanced Care Management*).

I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum:

1) Explain ECM and how a Member may to request it;

2) Maintain a list of ECM Providers as part of its Provider Directory, adherent to requirements established in the ECM Policy Guide;

~~2~~**3**) Explain that ECM participation is voluntary and can be discontinued at any time;

~~3~~**4**) Explain that the Member must authorize ECM-related data sharing;

~~4~~**5**) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

~~5~~**6**) Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.4.2 Populations of Focus for Enhanced Care Management

A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*).

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following Populations of Focus, as described in the ECM Policy Guide

1) Members experiencing homelessness:

a) Members without dependent Children/youth living with them experiencing homelessness; and

b) Homeless families or unaccompanied Children/youth experiencing homelessness.

2) Members at risk for avoidable hospital or emergency department utilization;

3) Members with serious mental health and/or Substance Use Disorder (SUD) needs;

4) Members transitioning from incarceration;

5) Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization;

6) A Member residing in an adult nursing facility transitioning to the community;

7) Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition;

8) Children involved in Child welfare; and

9) ~~Pregnant and postpartum Members; b~~**B**irth equity population of focus.

C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full but may benefit from ECM.

D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus**, and the JI Policy and Operations guide, that**

further define the approach to ECM for the Justice Involved Population of Focus.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

a) Multipurpose Senior Services Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) HCBS programs for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medicaid including:

a) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);

b) Program for All-Inclusive Care for the Elderly (PACE);

c) Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and

d) Non EAE D-SNPs.

3) California Community Transitions (CCT) Money Follows the Person (MFTP)

4) Complex Care Management (CCM)

4.4.3 Enhanced Care Management Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County Behavioral Health Providers;

3) Primary Care Provider (PCP) or Specialist or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals);

8) Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP);

9) Local Health Departments (LHDs);

10) Behavioral Health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers (CHW)

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the Population of Focus for eligible individuals with Serious Mental Illness (SMI) or SUD and the Population of Focus for eligible individuals with Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their Behavioral Health Services.

D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member Care Coordination and Care Management needs; and

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, LTC facility, housing status).

G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (*Data System Requirements and Data Sharing to Support Enhanced Care Management*).

H. Contractor must ensure all ECM Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013 (Provider Credentialing/Recredentialing and Screening/Enrollment). If APL 22-013 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or

delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

J. Contractor must ensure ECM Providers serving the Justice Involved Population of Focus meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to:

1) Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs:

a) If the Correctional Facilities in the ECM Provider's county of operation leverage an in-reach care management model, Contractor must ensure that JI ECM Providers offer pre-release care management services as in-reach care management Providers and continue to serve the Member post-release as the Member's ECM Provider.

b) If the Correctional Facilities in the ECM Provider's county of operation leverage an embedded care management model, Contractor must ensure that the ECM Provider participates in a warm handoff with the pre-release embedded care manager and the Member.

2) ECM Providers must bill Fee-for-Service (FFS) for all pre-release care management services and warm handoffs by either enrolling through the Provider Application and Validation for Enrollment (PAVE) system or contracting with the Correctional Facility to provide services billed under the Correctional Facility National Provider Identifier (NPI).

4.4.4 Enhanced Care Management Provider Capacity

A. Contractor must develop and manage a network of ECM Providers.

B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM Populations of Focus, including by contracting with providers with specific skills and experience serving specific Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.*5 (Enhanced Care Management Model of Care)* and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:

1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one or more of the Populations of Focus in one or more counties;

2) There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers;

3) Contractor and the ECM Providers are unable to agree on rates;

4) ECM Providers are unwilling to contract;

5) ECM Providers are unresponsive to multiple attempts to contract;

6) ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment

process or Contractor's verification requirements for ECM Providers; or

7) ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (*Sanctions*).

I. Contractor must ensure Network overlap of the Justice Involved pre-release care management Provider network and the Justice Involved ECM Provider network across Contractor's Service Area. Contractor must submit to DHCS, for prior approval, any requests for exception from Network overlap requirements across Medi-Cal managed care plans in the same county for one of the permissible reasons as described in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative.

4.4.5 Enhanced Care Management Model of Care

A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.

B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.

4.4.6 Member Identification for Enhanced Care Management

A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

B. To identify such Members, Contractor must consider the following:

1) Members' health care utilization;

2) Needs across physical, behavioral, developmental, and oral health;

3) Health risks and needs due to Social Drivers of Health; and,

4) Long-Term Services and Supports needs.

C. Contractor must identify Members for ECM through the following pathways:

1) Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

h) SMI/SED/SUD data, if available;

i) Risk stratification information for Children in County Organized Health System (COHS) counties with WCM programs;

j) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i. ECM Providers;

ii. Social service or other Providers; and

iii. Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Community Supports Providers)*.

b) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

c) Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members, with the goal of having the majority of ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification.

d) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.

3) Requests from Members

a) Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, ARs, caregivers, and authorized support persons to request ECM on a Member's behalf.

b) Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

4) For pre-release services under the Justice Involved Reentry Initiative, Contractor must have processes that:

a) Identify any Member who received pre-release services for presumptive eligibility and enrollment in ECM, including using the JI aid code for enrolled Members.

b) Receive notifications of pre-release services from Correctional Facilities or their contracted pre-release care managers through their JI liaison.

c) Receive notifications from the ECM Provider who is acting as the pre-release care manager or who has received a warm handoff.

4.4.7 Authorizing Members for Enhanced Care Management

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM Population of Focus eligibility requirements, Contractor must authorize ECM without additional requirements.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

D. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.

E. Contractor must authorize ECM services for all Members who were found eligible for pre-release services under the CalAIM Justice Involved Reentry Initiative. ECM services are authorized for 12

months per the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

~~E~~**F.** To inform Members that ECM has been authorized , Contractor must follow its standard notice process outlined in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and APL 21-011.

4.4.8 Assignment to an Enhanced Care Management Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*Enhanced Care Management Provider Capacity*).

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule.

D. Pursuant to the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, for Members eligible for pre-release services under the CalAIM Justice Involved Reentry 1115 Initiative, Contractor must, to the extent possible, assign an ECM Provider that was the pre-release care manager or the care manager who received a warm handoff from the Correctional Facility while the individual was incarcerated.

~~D~~**E**. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

~~E~~**F**. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

~~F~~**G**. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor

identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

~~G~~**H**. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

~~H~~**I**. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten Working Days of the date of assignment.

~~I~~**J**. Contractor must document the Member's ECM Lead Care Manager in its system of record.

~~J~~**K**. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.

4.4.9 Initiating Delivery of Enhanced Care Management

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal

guardians, ARs, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting.

D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

4.4.10 Discontinuation of Enhanced Care Management

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*); Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*); and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.4.11 Core Service Components of Enhanced Care Management

Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs:

A. Outreach and engagement;

B. Comprehensive assessment and Care Management Plan (CMP);

C. Enhanced coordination of care;

D. Health promotion;

E. Comprehensive transitional care;

F. Member and family supports; and

G. Coordination of and referral to community and social support services

4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*);

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing PHI and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s)

and/or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers.

1) Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Drivers of Health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS **in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework, in accordance with H&S section 130290**.

4.4.13 Oversight of Enhanced Care Management Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC.

1) Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

2) Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all Populations of Focus;

3) Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B (*Subcontractor and Downstream Subcontractor Agreement Requirements*).

B. **<u>Contractor may hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS to support data collection and reporting.</u>**

<u>1)</u> Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

<u>2)</u> Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary,

in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training).*

E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor.

Contractor may collaborate with its Subcontractors and Downstream Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for ECM Providers and Members.

4.4.14 Payment of Enhanced Care Management Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (*Initiating Delivery of Enhanced Care Management*).

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*).

4.4.15 Enhanced Care Management Reporting Requirements

A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1) Encounter Data:

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Section 1.19 (*Sanctions*).

4.4.16 Enhanced Care Management Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*) and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports
4.5.2 DHCS Pre-Approved Community Supports
4.5.3 Community Supports Providers
4.5.4 Community Supports Provider Capacity
4.5.5 Community Supports Model of Care
4.5.6 Identifying Members for Community Supports
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status
4.5.8 Referring Members to Community Supports Providers for Community Supports
4.5.9 Data System Requirements and Data Sharing to Support Community Supports
4.5.10 Contractor's Oversight of Community Supports Providers
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors
4.5.12 Payment of Community Supports Providers
4.5.13 Community Supports Reporting Requirements
4.5.14 Community Supports Quality and Performance Incentive Program

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*).

This Section (Section 4.5) refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 Code of Federal Regulations (CFR) section 438.3(e)(2), all applicable All Plan Letters (APLs), and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. See Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*) below for the list.

1) Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide, as referenced in APL 21-017 and the Community Supports Policy Guide.

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations incorporated in the Community Supports Policy Guide.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined in the Community Supports Policy Guide.

D. If Contractor elects to offer one or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.4 (*Community Supports Provider Capacity*).

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 (*Identifying Members for Community Supports*).

F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.7 (*Authorizing Members for Community Supports and Communication of Authorization Status*).

G. Contractor may elect to offer value-added services in addition to offering one or more Community Supports. Offering or not offering Community Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services*).

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs

Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

4.5.2 DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing transition navigation services;

2) Housing deposits;

3) Housing tenancy and sustaining services;

4) Short-term post-hospitalization housing;

5) Recuperative care (medical respite);

6) Respite services;

7) Day habilitation programs;

8) Nursing facility transition/diversion to assisted living facilities;

9) Community transition services/nursing facility transition to a home;

10) Personal care and homemaker services;

11) Environmental accessibility adaptations;

12) Medically tailored meals/medically supportive food;

13) Sobering centers; and

14) Asthma remediation.

B. Contractor must list all Community Supports it offers in its Community Supports Model of Care (MOC) template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with APLs and DHCS' Community Supports Policy Guide.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section 4.5 and are subject to the limitations of 42 CFR section 438.3(e)(1).

4.5.3 Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate,

with Community Supports Providers for the delivery of Community Supports elected by Contractor.

C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

2) Support Community Supports Provider notification to Contractor, ECM Providers, and Member's Primary Care Provider (PCP), as applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*).

E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal managed care health plans offering Community Supports in the same county.

F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities (SNFs), medically tailored meals providers).

4.5.4 Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

4.5.5 Community Supports Model of Care

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.6 Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable DCHS APLs.

B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will receive requests to evaluate Members for Community Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation.

1) Contractor's policies and procedures must include a framework for considering medical appropriateness in relation to Contractor's proposed approach for providing Community Supports.

2) Each Community Support authorization request must be considered separately for a Member. Contractor must evaluate each authorization request for medical appropriateness. Receiving

one Community Support does not preclude a member from being authorized for additional Community Supports unless a conflict is specified by DHCS.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, Skilled Nursing Facility (SNF) stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with APLs and to be defined in forthcoming guidance.

D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replace, pending authorization of the requested Community Supports.

E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs.

F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were

not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost-effective.

H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.5.8 Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor must submit to DHCS policies and procedures for review and approval prior to implementation.

1) For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers, and other authorized support persons, if Contractor intends to do so.

4.5.9 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS **in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, when sharing**

physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.10 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract, and APLs.

C. Contractor must use APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS;

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Subsection 4.5.13 (*Community Supports Reporting Requirements*); and

3) Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*).

G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.

4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors

A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*);

2) Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

3) Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

4) Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3

(*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

6) Contractor must make all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements mirror the requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

4.5.12 Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claims, bills, or invoices

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is

expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor must ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices.

2) Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered.

4.5.13 Community Supports Reporting Requirements

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor **must** comply with DHCS guidance on billing and invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoicing ~~or~~**and** billing data into the

national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services (CMS), or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Section 1.19 (*Sanctions*).

4.5.14 Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and

outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements
4.6.2 Grievance Process
4.6.3 Discrimination Grievances
4.6.4 Notice of Action
4.6.5 Appeal Process
4.6.6 Responsibilities in Expedited Appeals
4.6.7 State Hearings and Independent Medical Reviews
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
4.6.9 Grievance and Appeal Reporting and Data

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements

Contractor must have in place a Member Grievance and Appeal system that complies with 42 Code of Federal Regulations (CFR) sections 438.228 and 438.400 - 424, 28 California Code of Regulations (CCR) sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. Contractor must ensure that its Grievance and Appeal system meets the following requirements:

A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.

B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.

C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with TTY/TDD and interpreter capability.

D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding:

1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational;

2) A Grievance regarding denial of a request for expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review.

F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contactor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.

G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*). Contractor must ensure that language assistance taglines and a nondiscrimination notice meeting the minimum requirements in APL 21-004 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices.

H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours.

I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must ensure that Network Providers, Subcontractors, and Downstream

Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2).

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14

calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

4) Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

B. Expedited Authorization Requests

1) In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i). .

2) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

3) Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending if applicable.

C. Retrospective Review

Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

D. Terminations, Suspensions, or Reductions

1) For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten

calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214.

2) For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*).

E. Required Information in Contractor's NOA Informing Member of Notice of ABDs.

Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following:

1) A clear and concise explanation of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination.

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision.

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal;

5) The Member's rights and information on the process to request a State Hearing after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A);

6) The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and Exhibit A, Attachment III, Subsection 4.6.8 (*Continuation of Services Until Appeal and State Hearing Rights Are Exhausted*) below; and

7) If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing.

F. For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*). In accordance with APL 22-002, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

G. Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for Contractor's action to the Member, as required.

4.6.5 Appeal Process

Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the

Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal.

B. If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A).

C. Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include:

1) Member's right to request a State Hearing;

2) How to request a State Hearing;

3) That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met;

4) If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and

5) The DHCS-approved "Your Rights" Attachment.

D. If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the

date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its

initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file

and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit to DHCS a monthly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e).

B. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

C. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also address access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers (CHW). The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person **and prevent avoidable negative health and social outcomes for individual Members** to treat the whole person. This entails partnerships with Local Health

Departments, Local Educational and Government Agencies, and other local programs and services including **county** social services **departments**, Child welfare departments, and justice departments. This Article also establishes oversight of Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care **and community-informed** care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's cultural and linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor's organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor’s Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member’s condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by 22 California Code of Regulations (CCR) section 51009.

C. Member's Right to Advance Directives

Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j).

1) Contractor must ensure that its process for a Member's right to have an Advance Directive in place is included in the Member Handbook. Information in the Member Handbook must include the

Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

5.1.2 Member Services Staff

A. Contractor must employ and train a sufficient number of staff knowledgeable about Contractor's policies and procedures and capable of providing information to Members or Potential Members.

B. Contractor must ensure its Member services staff are trained and educated on all contractually required services for Members including policies and procedures on the scope of services required to be offered under this Contract, how to utilize services in the Medi-Cal program, how to access carved out services, and how obtain referrals to appropriate community resources and other agencies.

C. Contractor must ensure its Member services staff are educated on assisting Members with disabilities, chronic conditions, and components of

Health Equity in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. *(Cultural and Linguistic Programs and Committees)*. This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution, and State Hearings.

D. Contractor's Member services staff must refer Potential Members to the DHCS Enrollment broker when Potential Members request Enrollment with Contractor.

E. Contractor's Member services staff must refer Potential Members to their local county office for Medi-Cal eligibility determinations or redeterminations.

F. Contractor must ensure its Member services staff assist Members with a warm hand-off to Subcontractors and Downstream Subcontractors when Member services functions are delegated under a Subcontractor Agreement or Downstream Subcontractor Agreement.

5.1.3 Member Information

A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10, Welfare and Institutions Code (W&I) section 14406, 22 CCR section 53895, and as set forth in this provision.

B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment.

C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 *(Member Information)*, Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS.

D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 21-004. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form letters, Notices of Action (NOAs), NABDs, Grievances or Appeals, welcome packets,

Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format.

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the

encrypted information.

c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

a) In a conspicuous place in all physical locations where Contractor interacts with the public;

b) In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL

21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor's nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

a) A written proposal on Contractor's letterhead addressed to "DHCS Contract Manager" requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

iii. Time frame for implementation.

iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that covers the cycle of production to delivery of personalized Provider Directories.

vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance with 42 CFR section 438.10(h), and sub-contractual

relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece of Member material offered, and identify the options Members will have for receiving their Member materials.

3) The notice must be compliant with all the requirements of this Contract and DHCS policy, and federal and State statutes and regulations on Member Information, including 42 CFR sections 438.10 and 438.404, and W&I section 14029.91. DHCS will approve Contractor's notices on a case-by-case basis.

4) DHCS reserves the right to require Contractor to revert to sending printed copies of the Provider Directory and Member Handbook to its Members, at any time.

H. Provider Directory

1) Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations.

2) Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required.

3) Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format.

4) Contractor must update and submit its paper and electronic Provider Directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). Contractor must submit under the following timelines:

a) A paper Provider Directory must be updated at least monthly, if Contractor does not have a mobile-enabled, electronic Provider Directory; or quarterly, if Contractor has a mobile-enabled, electronic Provider Directory; and

b) An electronic Provider Directory must be updated no later than one week after Contractor receives updated provider information.

5) Contractor's Provider Directory submission must include complete, accurate and updated Provider Directory and Network information and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all requirements in PL 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H (*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and H&S section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers (CHW)) contracted for Medi-Cal Covered Services:

a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS paneled provider;

c) Whether the Provider is accepting new patients;

d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI number, address, telephone number, and, if applicable,

website URL for each Physician Provider of affiliated group or IPA;

e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;

g) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

h) The telephone number to call after normal business hours;

i) Identification of Network Providers or sites that are not available to all or new Members

j) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member.

Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:

   a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

   b) Information on how to access services in the Medi-Cal managed care system, including a description of the full amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access

standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and Non-Emergency transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

   i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

   ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22

CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request an State Hearing, and the rules that govern representation in an State Hearing. Contractor must ensure the following information is included:

i. The circumstances under which an expedited State Hearing is possible;

ii. Information stating that Contractor will assist in completing the State Hearing request when a health care service requested by the Member or Provider has been denied, delayed, or modified, as required by APL 21-011;

iii. The timelines which govern a Member's right to a State Hearing, pursuant to W&I section 10951 and for an expedited State Hearing pursuant to W&I section 10951.5;

iv. The Department of Social Services (DSS) Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing; and

v. Contractor's obligation to continue the disputed service(s) until there is a final decision on the State Hearing as long as if the Member requests a State Hearing in the specified timeframe(s) as required by 42 CFR section 438.420.

p) The availability of, and procedures for obtaining services at FQHCs, RHCs and IHCPs;

q) The Member's right to seek family planning services from any qualified family planning Provider in the Medi-Cal program, including out-of-Network Providers; how to access these services; that a referral is not necessary; and a description of the limitations on the services that Members may seek out-of-Network. The DHCS Office of Family Planning toll-free telephone number (1-800-942-1054) that provides consultation and referral to family planning clinics

must also be included. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of Children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Providers and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that doctor or clinic for the family planning services you get.

r) Procedures for providing female Members with direct access to an in-Network women's health Specialist for women's preventive and routine health care services without requiring Prior Authorization. Access to a women's health Specialist must be provided in addition to the Member's designated PCP if the PCP is not a women's health Specialist;

s) Information on the availability of and procedures for obtaining Certified Nurse Midwife (CNM) and Nurse Practitioner services, pursuant to Exhibit A, Attachment III, Subsection 5.2.8.G. (*Specific Requirements for Access to Programs and Covered Services*);

t) Information on how to access the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll-free telephone number (1-800-400-0815) for resolution of Member concerns and complaints;

u) Information on the provision and availability of services covered under the California Children's Services (CCS) Program from out-of-Network Providers, and how to access CCS Program;

v) Information on how to obtain Minor Consent Services through Contractor's Network, an explanation of those services, and information on how Minor Consent Services

can also be obtained from out-of-Network Providers without requiring Prior Authorization;

w) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members less than 21 years of age, and that it includes all Medically Necessary health care, diagnostic services, treatments, and other measures listed in 42 United States Code (USC) section 1396d(a) and (r), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor's Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor's newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from Contractor, their Network Provider, or the Network Provider's medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor's non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected

at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), OB-GYN, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, NP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 18-008 (revised).

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to

require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
5.2.7 Out-of-Network Access
5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
5.2.14 Site Review
5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and

coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor's Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor's Service Area. Contractor's Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and

Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. **Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards.** Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist. ~~Contractor may, but is not obligated to, contract with CBAS~~

~~Providers licensed as Adult Day Health Care (ADHC) and certified by California Department of Aging (CDA) to provide CBAS on or after April 1, 2012.~~

5.2.4 Network Ratios

A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2)) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:

1) FTE Primary Care Providers that are Physicians: Member: 1:2,000

2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

1) Physician Supervisor: Nurse Practitioners 1:4

2) Physician Supervisor: Physician Assistants 1:4

3) A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

5.2.5 Network Adequacy Standards

A. Timely Access

1) Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197 (d)(1)(A), 28 CCR section 1300.67.2.2, and the requirements in this Contract.

2) Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors:

a) Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2:

   i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

   ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

   iii. Non-urgent appointments for Primary Care within ten (10) business days of request;

   iv. Non-urgent appointments with Specialists within 15 business days of request;

   v. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

   vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within fifteen (15) business days of request;

   vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five (5) business days of request;

   viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven (7) business days of request; and

   ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera,

Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba within 14 business days of request.

b) Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

   i. 0The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

   ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

   iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

c) Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments;

d) Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and

e) Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

3) During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes.

4) Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns.

5) Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001 detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and 1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

b) Limited history and physical examination;

c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

e) Provision of contraceptive pills, devices, and supplies;

f) Tubal ligation;

g) Vasectomies; and

h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for Members less than 18 years of age from any Network Provider or out-of-Network

Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, and Contractor, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Sexual assault, including rape;

2) Drug or alcohol abuse for Children ages 12 and over;

3) Pregnancy;

4) Family planning;

5) STDs in Children ages 12 and over;

6) Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and

7) NSMHS for Children ages 12 and over who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

E. Immunizations

Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

F. Indian Health Care Providers

Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network

PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

G. Certified Nurse Midwife and Nurse Practitioner Services

1) Contractor must ensure that its Members have access to CNM services as required by 42 United States Code (USC) section 1396d(a)(17) and 22 CCR section 51345.

2) Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1.

3) Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in-Network.

H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection

1) If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

2) Contractor's Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure.

I. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

Contractor must meet federal requirements for access to a FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

J. Community Based Adult Services

Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following:

1) Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

2) Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

5.2.9 Network and Access Changes to Covered Services

A. DHCS Notification Requirements

1) Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible.

2) Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

3) Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the

CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution

letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;

c) Referrals to culturally and linguistically appropriate community service programs; and

d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services

by Contractor's staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4).. Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA) **implementation and subsequent findings**. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following:

   a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

   b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the

Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 21-004, and Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*).

c) Use of national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

d) An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

e) A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included;

f) The role of the PNA to inform Contractor's cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

g) The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training; and

h) Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees and Contracted Staff

Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to

address Members' cultural and linguistic needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 *(Cultural and Linguistic Programs and Committees).*

C. Diversity, Equity, and Inclusion Training

Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may

impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

   a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC:

      i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

      ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

   b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

c) Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

d) Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

e) Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to:

   i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;

   ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

   iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

   iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

   v. Ensuring compliance with all CAC reporting and public posting requirements; and

   vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not

be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and **at least** quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

4) Duties of the CAC

The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

a) Identifying and advocating for Preventive Care practices to be utilized by Contractor;

b) Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d) The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health. Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies;

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

   i. Culturally appropriate service or program design;

   ii. Priorities for health education and outreach program;

   iii. Member satisfaction survey results;

   iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management;

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

~~a)~~ To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following:

~~i.~~**a)** The demographic composition of CAC membership;

~~ii.~~**b)** How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

~~iii.~~**c)** The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

~~iv.~~**d)** Barriers to and challenges in meeting or increasing alignment between CAC's membership with the

demographics of the Members within Contractor's Service Area;

~~v.~~**e)** Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

~~vi.~~**f)** A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

5.2.12 Continuity of Care for Seniors and Persons with Disabilities

A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider.

B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL ~~22-032~~**23-022.**

C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met:

1) The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;

2) The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and

3) The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.

D. Contractor must conduct Person-Centered Planning for SPD Members as follows:

1) Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD Member's continuing health care needs.

2) Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities.

3) Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice.

5) Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.

E. Contractor must ensure the provision of Discharge Planning when a SPD Member is admitted to a hospital or institution and continuation into the post-discharge period. Discharge Planning must include ensuring that necessary care, services, and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. The minimum criteria for a Discharge Planning checklist must include:

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

2) Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an

AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports.

3) Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended.

4) Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

5.2.13 Network Reports

A. Network Certification Report

1) Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001.

2) Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45.

3) Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2).

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e) Contractor must submit its Network certification report as outlined in APL 23-001.

B. Periodic Reporting Requirements

1) Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and

Contractor's ability to provide health care services, such as the following:

a) Change in Covered Services or benefits;

b) Change in geographic Service Area;

c) Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or

d) Enrollment of a new population.

2) Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207.

C. Network Change Report

1) Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network.

2) Contractor must submit the report 30 calendar days following the end of the reporting quarter.

D. Subcontractor and Downstream Subcontractor Network Certification Report

1) Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (*Network Ratios*), Network Adequacy Standards set forth in Subsection 5.2.5 (*Network Adequacy Standards*), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*) of this Contract in accordance with APL 23-006.

2) Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit

A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*).

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006. Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (*Network Adequacy Standards*) by supplementing the Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved.

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.

5.2.14 Site Review

A. General Requirement

1) Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207.

2) Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

B. Pre-Operational Site Reviews

The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six (6) weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six (6) weeks prior to Contractor operation.

C. Credentialing Site Review

A Site Review is required as part of the Credentialing process when both the facility and the Provider are added to Contractor's Network. If a Provider is added to Contractor's Network, and the Provider site has a current passing Site Review survey score, a site survey need not be repeated for Provider Credentialing or recredentialing purposes.

D. Corrective Action

Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003.

E. Data Submission

Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

F. Continuing Oversight

Contractor must retain accountability for all Site Review activities even if this function is delegated.

G. Medical Record Documentation

1) General Requirement

Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

2) Medical Records

Contractor must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to:

a) For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

b) To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

c) For the release of information and obtaining consent for treatment; and

d) To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

3) On-Site Medical Records

Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

4) Member Medical Record

Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) Member's preferred language (if other than English) prominently noted in the record, as well as the request or

refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

c) All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

d) A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

e) Allergies and adverse reactions prominently noted;

f) All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable;

g) Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

h) Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

i) For Medical Records of adults, documentation of whether the individual has been informed and has executed an Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

j) Health education behavioral assessment and referrals to health education services where appropriate; and

k) Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity

Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

5.2.15 Street Medicine

Contractor may provide medical and other Covered Services as described in APL ~~22-023~~**24-001** via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL ~~22-023~~**24-001**. This subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.

A. Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on

the street, the Street Medicine Provider must be affiliated with a facility that has a physical location.

B. Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care Coordination, administrative, billing and claim, data sharing, and reporting requirements.

C. Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or APL 21-017. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.

D. Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.

Exhibit A, ATTACHMENT III

5.3 Scope of Services

5.3.1 Covered Services
5.3.2 Medically Necessary Services
5.3.3 Initial Health Appointment
5.3.4 Services for Members Less Than 21 Years of Age
5.3.5 Services for Adults
5.3.6 Pregnant and Postpartum Members
5.3.7 Services for All Members
5.3.8 Investigational Services

5.3 Scope of Services

5.3.1 Covered Services

A. Contractor must provide or arrange for all Covered Services for Members, in accordance with the definition of Covered Services set forth in Exhibit A, Attachment I, Article 1.0 (*Definitions*). Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. Contractor has the primary responsibility to provide all Covered Services, including services that exceed the services provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs.

B. Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member's ongoing needs, including but not limited to services for chronic conditions.

C. Except as set forth in Attachment 3.1.B.1 of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code (W&I) section 14133.23, drug benefits for Members who are eligible for drug benefits under 42 United States Code (USC) section 1395w-101 *et seq.*) are not a Covered Service under this Contract. Contractor must comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Policy Letter (PL) 108–173, December 8, 2003, 117 Stat 2066.

D. Unless expressly excluded under this Contract, Contractor must cover any services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder (SUD) benefits, and ensure that Members are given access to all mental health and SUD services in accordance with 42 Code of Federal Regulations (CFR) section 438.900. The types, amount, duration, and scope of these services must be

consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or SUD services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I section 14132.72, and as follows:

1) Contractor is responsible for ensuring that Covered Services provided via a Telehealth modality meet DHCS guidelines in outlined in the Provider Manual.

2) Contractor must oversee that Providers only provide Covered Services that can be appropriately delivered via Telehealth, and that they not provide Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member 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.

3) Contractor must ensure all Providers furnishing applicable Covered Services via audio-only synchronous interactions also offer those same services via video synchronous interactions.

4) Contractor must ensure all Providers furnishing services through video synchronous interactions or audio-only synchronous interactions must do one of the following:

a) Offer those same services via in-person, face-to-face contact.

b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any

required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children’s Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children’s preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each Non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children’s preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children’s preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member’s (if an emancipated minor), or the parent, legal guardian, or AR of the Member’s voluntary refusal of these services.

4) All children’s preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2

(*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each Non-Emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

4) Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization

purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

   a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

   b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

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2) Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to 17

CCR section 37100. For a period of no less than ten years, Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.

3) If the Member, or the Member's parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member's Medical Record.

4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR refuses or declines to sign, or is unable to sign, such as when services are provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.

5) DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (*Services for Members Less Than 21 Years of Age*) as evidence of Contractor's compliance with blood lead screening test requirements.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*),

Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.

2) Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (*Services for Members Less Than 21 Years of Age*), above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

3) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System (DMC-ODS)Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.

F. Behavioral Health Treatment Services

For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings (MOUs) with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in ~~APL 18-009,~~ APL 22-005 and APL 22-006. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC,~~ as required by APL 18-009,~~ Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency Services

Contractor must reimburse LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services).*

H. Rapid Whole Genome Sequencing
Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a Covered Service for any Medi-Cal Member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I section 14132(ae).

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment.

2) Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

B. Adult Preventive Services

Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows:

1) Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

2) Contractor must cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. Contractor must ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

3) Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

2) In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

3) At each non-emergency Primary Care Encounter the Member must be advised of the vaccinations due and available from Contractor, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

4) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports will be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable State and federal laws.

5.3.6 Pregnant and Postpartum Members

A. Prenatal and Postpartum Care

Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum. Contractor must

utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.

B. Risk Assessment

Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and,~~ensure access to genetic screening with appropriate referrals~~**are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services**. Contractor must ensure that pregnant and postpartum Members **receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure access to genetic screening with appropriate referrals**. ~~are referred to Doulas as required under~~ **Members may receive one initial visit; eight visits at any time during the perinatal period; services during labor and delivery, miscarriage, or abortion; and two extended postpartum visits with the standing recommendation issued by DHCS. An additional nine visits during the postpartum period is available with a**

second recommendation from a licensed provider. Contractor must comply with ~~W&I section 14132.24~~ **section 440.130(c) of Title 42 of the Code of Federal Regulations when making a recommendation for Doula services**. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

5.3.7 Services for All Members

A. Health Education

1) Contractor must implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all Members.

2) Contractor must ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor must provide evidence-based health education programs and services to Members, directly, or through Subcontractors, Downstream Subcontractors, or Network Providers.

4) Contractor must ensure organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health. Contractor may offer Members non-monetary incentives for participating in incentive programs, focus groups, and Member surveys authorized by W&I section 14407.1 pursuant to APL 16-005.

5) Contractor must ensure that health education materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for the intended audience in accordance with APL 18-016.Contractor must review health education materials to ensure documents are up-to-date.

6) Contractor must ensure availability of Community Health Workers (CHWs) to all Members. CHWs should provide services to include

but are not limited to assisting Members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources.

7) Contractor must maintain a health education system, or use a DHCS-sponsored system if available, that provides educational interventions addressing health categories and topics that align with the Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

8) Contractor must ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor must provide education, training, and program resources to Network Providers for the delivery of health education services.

9) Contractor must maintain health education policies, procedures, standards, and guidelines. Contractor must maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor must monitor the health education system including accessibility for Limited English Proficient (LEP) Members and the performance of Providers that are contracted to deliver health education services. Contractor must ensure appropriate allocation of health education resources and conduct appropriate levels of program evaluation.

B. Hospice Care

1) Contractor must cover and ensure the provision of hospice care services as defined in 42 USC section 1396d(o)(1) and as required by APL 13-014. Contractor must ensure that Members and their families are fully informed of the availability of hospice care as a Covered Service and the methods by which they may elect to receive these services. In accordance with APL 13-014, a hospice must obtain written certification of terminal illness for each hospice benefit period. “Terminally ill,” as defined in 42 CFR section 418.3,

means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Services are limited to Members who directly or through their AR voluntarily elect to receive hospice care in lieu of other care as specified. However, for Members less than 21 years of age, a voluntary election of hospice care does not constitute a waiver of any rights of that Member to be provided with, or to have payment made for, Covered Services that are related to the treatment of that Member's condition for which a diagnosis of terminal illness has been made.

2) For Members who have elected hospice care, Contractor must arrange for continuity of care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor must cover the cost of all hospice care provided. Contractor must also cover all Medically Necessary care not related to the terminal condition.

C. Palliative Care

Contractor must cover and ensure the provision of palliative care, as required by W&I section 14132.75 and as set forth in APL 18-020, and as required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. Contractor must continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, Contractor must cover palliative care concurrently with hospice care and other Medically Necessary Covered Services if hospice care is elected by the Member.

D. Vision Care – Lenses

Contractor must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories except when the Member requires lenses not available through PIA. Contractor must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of fabrication and dispensing of lenses not available through PIA.

E. Mental Health and SUD Services

Contractor must cover all Medically Necessary mental health and SUD services specified in Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*) in compliance with mental health parity requirements in 42 CFR section 438.900 *et seq*., and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

F. Organ and Bone Marrow Transplant Surgeries

Contractor must cover all Medically Necessary organ and bone marrow transplant surgeries as set forth in the Medi-Cal Provider Manual, including all updates and amendments to the Manual.

1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.

2) Contractor must authorize and cover costs for organ or bone marrow transplants for Members. Contractor must cover all pre and post-operative transplant-related costs such as, but not limited to, evaluation, hospitalization, and all Medically Necessary services such as transportation and prescriptions not covered by and billable to Medi-Cal Rx.

3) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member's condition requires it, or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

4) Contractor must refer Members less than 21 years of age identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility, if necessary, unless Contractor is responsible for the CCS benefit (Whole Child Model contracts only). Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC) **or DHCS-approved Centers of Excellence.** If the CCS Program determines that the Member is not eligible for the CCS Program or the MOT is not related to the Member's CCS

eligible medical condition, but the MOT is Medically Necessary, Contractor must refer the Member to a transplant program within 72 hours of receipt of the eligibility determination and is responsible for authorizing the MOT, as appropriate.

5) Contractor must refer Members less than 21 years of age to the appropriate CCS-approved Special Care Center that meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.

6) For Members less than 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

7) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

8) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.

9) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

10) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.

11) Contractor must cover all Medically Necessary physician administered drugs provided to a Member or the living donor administered by a health care professional in a clinic, physician's

office, or outpatient setting and is needed for the Member receiving an organ or bone marrow transplant, such as anti-rejection medication, and any other Medically Necessary Prescription Drug not covered by Medi-Cal Rx.

G. Long-Term Care Services

Contractor must authorize and cover Long-Term Care (LTC) services as set forth in APL 23-004**, APL 23-023, and APL 23-027**. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6**, W&I section 14132.25** and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Contractor must place Members in LTC facilities that are licensed and certified by the California Department of Public Health (CDPH). Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

3) Contractor must provide continuity of care to Members through continued access to the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

4) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level

of care, including offering to contract with facilities within and outside of the Service Area.

5) Contractor must provide Transitional Care Services as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*).

6) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF~~D~~/DD-H), and ICF/DD-Nursing (ICF/DD-N) **homes** are not LTC services consistent with 22 CCR section 51544(h).

7) Contractor must ensure that Members in need of ICF/DD, ICF/DD-H, and ICF/DD-N services are placed in the ICF/DD Home deemed most appropriate to the Member's medical needs as specified in the Individualized Program Plan (IPP) issued by the Member's Regional Center.

H. Pharmaceutical Services

1) Drug Use Review (DUR)

Contractor must develop and implement effective DUR and treatment outcome process, as directed in APL 17-008, APL ~~19-012~~**23-026**, and APL 22-012 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DUR must meet or exceed the requirements described in 42 USC section 1396r-8(g) and 42 CFR section 438.3(s), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.

b) Contractor's DUR must implement:

i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

ii. A program to monitor and manage the appropriate use of antipsychotic, medications by all Children 18 years of age and under including foster Children enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(oo)(1)(B), APL 19-012**23-026**, and APL 22-012; and

iii. Fraud and abuse identification processes for potential Fraud or abuse of controlled substances by Members, Providers, and pharmacies.

c) Contractor must annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

2) Contractor must not impose Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and SUD drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR section 438.900 *et seq*.

I. Transportation

Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.

1) Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.

2) Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323.

a) Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider before Prior Authorization can be granted for NEMT services. For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides

for the duration of the recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Service (SMHS), SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

4) Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.

5) Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(ad), and APL 22-008, Contractor must also cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

J. Care Management and Care Coordination

1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*).

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*). Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).

K. Dyadic Services

Contractor must provide Dyadic Services and the Family Therapy benefit for Members less than 21 years of age and/or their caregivers in an outpatient setting as Medically Necessary as set forth in APL 22-029 and detailed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including CHWs, are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

a) Under the supervision of a supervising Provider from one of the provider types listed above, CHWs can assist a dyad to gain access to needed services to support their health through the CHW benefit for health navigation services

b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

a. The DBH well-Child visit must be limited to those services not already covered in the medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same day as the medical well-Child visit. When this is not possible, Contractors must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

bb. Developmental history of the Child.

cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

dd. Mental status assessment of parent(s) or caregiver(s).

ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

ff. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

gg. Age-appropriate anticipatory guidance focused on Behavioral Health promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACEs Screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than 21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

i. Members less than 21 years of age with a diagnosis of a mental health disorder;

ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental health disorder;

iii. Members less than 21 years of age with a history of at least one of the following risk factors:

a. Neonatal or pediatric intensive care unit hospitalization;

b. Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment);

c. Death of a parent or caregiver of Foster home placement;

d. Food insecurity, housing instability;

e. Maltreatment;

f. Severe and persistent bullying; and

g. Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability;

iv. Members less than 21 years of age who have a parent(s) or caregiver(s) with one or more of the following risk factors:

a. A serious illness or disability;

b. A history of incarceration;

c. Depression or other mood disorder;

d. Post-Traumatic Stress Disorder or other anxiety disorder;

e. Psychotic disorder under treatment;

f. SUD;

g. Job loss;

h. A history of intimate partner violence or interpersonal violence; and

i. Is a teen parent.

e) Contractor must provide Family Therapy services if needed to correct or ameliorate a Child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

f) Members less than 21 years of age may receive up to five Family Therapy sessions before a mental health diagnosis is required. Contractor must provide Family Therapy without regard to the five-visit limitation for Members less than 21 years of age with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/ persistent bullying; and discrimination.

5) Billing and Claims

a) Dyadic Services Providers must be reimbursed in accordance with their Network Provider contract.

b) Contractor must not require Prior Authorization for Dyadic Services.

c) Contractor must not establish unreasonable or arbitrary barriers for accessing coverage.

d) Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

e) Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate.

f) The DBH well-Child visit must be limited to those services that are not already covered in the medical well-Child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-Child visit or a DBH well-Child visit.

g) Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the Child) may be billed by either the medical well-Child Provider or the DBH well-Child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers.

h) Tribal Health Programs, Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from Contractor if Dyadic Services are provided by a billable Provider per APL 17-002 and APL 21-008.

i. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations.

ii. THP, RHC, and FQHC Providers can bill FFS for Dyadic Services delivered in a clinical setting by Provider types named in the Non-specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

iii. THP, RHC, and FQHC Providers cannot double bill for Dyadic Services that are duplicative of other services provided through Medi-Cal.

iv. All Dyadic Services must be billed under the Medi-Cal identity of the Member less than 21 years of age.

L. Practice Guidelines

Contractor must adopt practice guidelines in accordance with 42 CFR section 438.236, and this Contract. Contractor’s decisions for Utilization Management, Member education, provision of Covered Services, and other areas covered by practice guidelines must be consistent with these guidelines. Contractor must also provide their practice guidelines, upon request, to Members and Potential Members.

M. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APSs), including clinic-based and home-based asthma self-education, and in-

home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) CHW Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

g) Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: o CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment,

professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider. 6 Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services

h) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. 7,8 A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

i) Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

j) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

k) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

~~4) By October 1, 2024, Contractor must have approved and operable policies and procedures to provide the CHW benefit within contracted hospitals offering Emergency Services. The CHWs must~~

~~have experience and training in violence prevention, mental health, and Substance Use Disorders.~~

O. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Networks within its Service Area, including for CHW Services as stated in APL 21-006.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/encounters, frequent hospital admissions or emergency department visits, demographic and Social Drivers of Health data, referrals from the community, and needs assessments.

P. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or out-of-Network Providers, within their scope of practice, including physician assistants, nurse practitioners, clinical nurse Specialists, podiatrists, nurse midwives, Licensed Midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Q. Cancer Biomarker Testing

Contractor must comply with APL 22-010 and cover Medically Necessary biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer and cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer. Contract is prohibited from imposing Prior Authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

R. COVID-19 Coverage

Contractor must cover COVID-19 related services to include prevention, testing, and treatment as detailed in APL 22-009.

5.3.8 Investigational Services

A. Contractor must cover investigational services as defined in 22 CCR section 51056.1(b) when a service is determined to be investigational pursuant to 22 CCR section 51056.1(c), and all requirements in 22 CCR section 51303(h) are met and documented in the Member's Medical Record.

B. Routine Patient Care Costs for Clinical Trials

1) **Contractor must cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with participation by Members in a qualifying clinical trial pursuant to 42 USC section 1396d(a)(30), and W&I section 14132.98. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.**

2) **Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.**

3) **Coverage of routine patient care costs must be provided regardless of geographic location or if the treating Provider or principal investigator of the qualifying clinical trial is a Network Provider.**

4) **Coverage of routine patient care costs must be based on Provider's and principal investigator's approval regarding the Member's appropriateness for the qualifying clinical trial.**

5) **The coverage determination must be expedited and completed within 72 hours.**

6) **Contractor must require the submission of the "Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for approval of the clinical trial. The attestation form must include the following information:**

   a) **The Member's name and client identification number;**

   b) **The national clinical trial number;**

   c) **A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and**

   d) **A statement signed by the Provider attesting to the appropriateness of the qualified clinical trial.**

Exhibit A, ATTACHMENT III

5.4 Community Based Adult Services

5.4.1 Covered Services
5.4.2 Coordination of Care
5.4.3 Required Reports for the Community Based Adult Services Program
5.4.4. Community Participation
5.4.5. Community Based Adult Services Program Integrity

5.4 Community Based Adult Services

5.4.1 Covered Services

In addition to Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover Community Based Adult Services (CBAS) in accordance with the California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions (STCs), including Sections V.A.19 through 30 and Attachments H and S, or in accordance with any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Contractor must cover CBAS and ensure provision of the following services:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM STCs Section V.A.20.a and b, Attachment H, and Exhibit A, Attachment III, Subsection 5.4.2.C. (*Coordination of Care*);

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider;

C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of Members eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area, as required by Exhibit A, Attachment III, Subsection 5.2.8.J. (*Specific Requirements for Access to Programs and Covered Services*). Arranging for unbundled CBAS services includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community, in accordance with the following requirements listed below.

1) Unbundled CBAS Covered Services are limited to the following:

a) Professional Nursing Services;

b) Nutrition;

c) Physical Therapy;

d) Occupational Therapy;

e) Speech and Language Pathology Services;

f) Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and

g) Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services;

2) Contractor must coordinate care for unbundled CBAS services that are not Covered Services based on the assessed needs of the Member eligible for CBAS, including:

a) Personal Care Services;

b) Social Services;

c) Physical and Occupational Maintenance Therapy;

d) Meals;

e) Specialty Mental Health Services (SMHS); and

f) SUD Services

D. Ensure that Member access to Medicare Providers or services is not impeded or delayed through Contractor's provision of CBAS; and

E. Ensure continuity of care, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), when Members switch Medi-Cal managed care plans and/or transfer from one CBAS Provider to another.

F. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM STCs Section V.A.21 and All Plan Letter (APL) 22-020. CBAS ERS must be provided in alternative Service Locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.

1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Health and Support Plan (IHSP). Contractor must assess Members at least every three months for ERS as part of the

reauthorization of the Member's Individual Plan of Care (IPC) and review for continued need for ERS.

2) Telehealth delivery of ERS must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.

3) Contractor must provide ERS under the following circumstances:

   a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and

   b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

5.4.2 Coordination of Care

A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*).

B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care".

C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must:

1) Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor has already determined Contractor must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

b) The name(s) of the Member's Physician(s);

c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;

d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*), Contractor must coordinate care for unbundled CBAS that are not

Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS:

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

5.4.5. Community Based Adult Services Program Integrity

Following a determination that a credible allegation of Fraud exists involving a CBAS Provider, DHCS must notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor must report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of Fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Terms and Conditions, GPR Section V.A.30.b.

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements
5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services
5.5.3 Non-specialty Mental Health Services Providers
5.5.4 Emergency Mental Health and Substance Use Disorder Services
5.5.5 Mental Health and Substance Use Disorder Services Disputes
5.5.6 No Wrong Door for Mental Health Services

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 Code of Federal Regulations (CFR) section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services

A. Non-specialty Mental Health Services (NSMHS) set forth in Welfare and Institutions Code (W&I) section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be

delivered in person and via Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the County Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 22-006 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 United States Code (USC) section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services

are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an Early Periodic Screening, Diagnosis and Testing (EPSDT) screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and Contractor must cover them. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

F. Contractor must cover mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults; ACE screening; brief emotional/behavioral assessments; depression screening; general developmental screening; autism spectrum disorder screening; and SBIRT Services. Contractor must develop and implement policies and procedures for mental health and substance use screenings and services provided by a PCP, including, but not limited to, provision of SBIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

G. Contractor must cover a mental health assessment without requiring Prior Authorization. Contractor must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract for authorizing additional mental health and SUD services. Consistent with the No Wrong Door policies set forth in W&I section 14184.402, Contractor must cover the assessment and any NSMHS provided during the assessment period for any Member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met, and even if the Member is later determined to need SMHS and/or SUD services and is referred to the MHP or to the County Department responsible for SUD treatment. Contractor must cover NSMHS even if the service was not included in the individual treatment plan, and even if the Member has a co-occurring mental health condition and SUD.

H. Contractor must develop and implement policies and procedures for tracking mental and Behavioral Health screenings, assessments, and treatment services provided by licensed mental health care Providers.

I. Contractor must cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member, including the following:

1) Emergency room professional services as described in 22 CCR section 53855 **including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member**;

2) Facility charges ~~for emergency room visits~~ **claimed by emergency departments per APL 22-005 and Behavioral Health Information Notice (BHIN) 22-011**;

3) All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition;

4) Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 22-008 and this Contract. These services include, but are not limited to, SMHS, Drug Medi-Cal (DMC) services, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services;

5) NMT services and, for Members less than 21 years of age, Non-Emergency Medical Transportation (NEMT) services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 22-008 and this Contract;

6) Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, County Mental Health Plan (MHP), or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

a) The initial health history and physical examination required upon admission, consultations, and any Medically Necessary Covered Services; Skilled Nursing Facility (SNF) room and board when psychiatric nursing facility services are provided to Members ~~less than 21 years of age or~~ age 65 and over.

b) Contractor must not cover other inpatient psychiatric facility/~~IMD~~ room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/~~IMD~~ per diem rate.

7) All Medically Necessary Medi-Cal covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under this Contract. This includes reimbursement for Medically Necessary Medi-Cal covered psychotherapeutic drugs administered by out-of-Network Providers for Members not otherwise excluded under this Contract;

8) Reimbursement to pharmacies for psychotherapeutic drugs must be provided through the Medi-Cal Fee-For-Service (FFS) program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program;

9) Contractor must not materially delay access to Covered Services per Paragraphs 3), 4), and 5) above through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through Contractor's Network, consistent with Contractor's obligation to provide timely Covered Services under this contract.

J. Contractor must use DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for Children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP's network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*).

K. If a Member becomes eligible for SMHS ~~during the course of~~ **while** receiving covered NSMHS, Contractor must continue the provision of non-

duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

1) Contractor must enter into a ~~Memorandum of Understanding (~~MOU~~)~~ with the MHP in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*). Likewise, Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*).

L. Contractor must make best efforts to ensure that a Member's existing mental health Provider is notified during an Urgent Care situation, when possible. Contractor must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.

M. Contractor must develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

N. Contractor must monitor and track utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (*Review of Utilization Data*).

5.5.3 Non-specialty Mental Health Services Providers

A. In addition to Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*), Contractor must increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will evaluate through the Network certification. Contractor may contract with any mental

health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per Health and Safety Code (H&S) section 1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (*Network Composition*). Contractor's NSMHS Providers must support current and desired service utilization trends for its Members.

1) Contractor must authorize and arrange for out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of out-of-Network Providers in Contractor's Service Area(s) must be prioritized over authorization of out-of-Network Providers in adjoining Service Area(s), unless an out-of-Network Provider in an adjoining Service Area(s) is more conveniently located for a Member or meets time or distance standards.

2) Contractor may contract with a MHP to ensure access to NSMHS.

   Contractor must develop and implement policies and procedures for the secure exchange of Member Information with the MHP to facilitate referrals and Care Coordination. The policies and procedures must cover:

   a) Sharing Protected Health Information (PHI) with the MHP for SMHS and the County Department responsible for SUD treatment, including when required by law, ~~and~~ obtaining Member authorization to release information that allows **the exchange of** treatment history, active treatment, and health information ~~to be exchanged~~;

   b) Data sharing agreements with the MHP for SMHS and the County Department responsible for SUD treatment and, when required by law, a Business Associate Agreement that addresses the sharing of information related to mental health services and SBIRT services; and

   c) Collecting and reporting data on Members receiving Medi-Cal NSMHS to the MHP.

B. Notwithstanding Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), if a NSMHS Provider is accredited by the National Committee for Quality Assurance (NCQA), Contractor may

deem the Provider credentialed or re-credentialed. Additionally, Contractor must develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 22-013.

C. Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor must ensure timely access to out-of-Network Providers and Telehealth Providers, in accordance with H&S section 1367.03 and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

5.5.4 Emergency Mental Health and Substance Use Disorder Services

In addition to the requirements set forth in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must have a MOU with the MHP to refer Members in need of Urgent Care and Emergency Services, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

5.5.5 Mental Health and Substance Use Disorder Services Disputes

If Contractor and an MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013.

A. Contractor must enter ~~into~~ a**n** MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to include a process for resolving disputes between Contractor and the MHP that includes a means for Members to receive Medically Necessary services, including NSMHS, while the dispute is being resolved.

B. Pursuant to 9 CCR section 1850.525, Contractor must not delay the provision of Medically Necessary services during the resolution of a dispute between Contractor and MHP. Contractor must comply with the rules set forth in 9 CCR section 1850.525 for determining the responsibility for managing ongoing care and financial responsibility for services provided to Members during the dispute period. When disputes concern Contractor's contention that the MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined that the Member's does not meet SMHS criteria,

Contractor must manage the care of the Member in accordance with 9 CCR section 1850.525 and APL 21-013 until the dispute is resolved.

C. Contractor must provide case management and Care Coordination for all Medically Necessary services, including those services that are the subject of a dispute between Contractor and an MHP.

D. Regardless of MOU status, Contractor and the MHP must adhere to the routine dispute resolution process and expedited dispute resolution process requirements set forth in APL 21-013.

E. If DHCS renders a decision for the dispute that includes a finding that Contractor is financially liable to the MHP for services, Contractor must comply with the requirements in 9 CCR section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

F. Contractor must monitor and track the number of disputes with MHPs. Upon request, Contractor must report all disputes to DHCS.

5.5.6 No Wrong Door for Mental Health Services

Contractor must implement policy to ensure that Members receive timely mental health services without delay regardless of the delivery system where they seek care, and are able to maintain treatment relationships with trusted Providers without interruption.

A. Contractor must provide or arrange for the provision of the following NSMHS:

1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.

2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

3) Outpatient services for purposes of monitoring drug therapy.

4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy Providers via Medi-Cal Rx.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor must provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members ages 21 and over with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

2) Members who are less than 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*EPSDT Services*) of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,

3) Members of any age with potential mental health disorders not yet diagnosed.

C. Contractor must cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor must, in a Primary Care setting, provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor must also provide or arrange for the provision of:

1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings; and

2) Emergency Services necessary to stabilize the Member.

E. Contractor must implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APL 22-005 and APL 22-028. Contractor must update and align policies and procedures and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary.

1) In accordance with APL 22-005, Members ages 21 and over must be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members less than 21 years of age must be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I section 14184.402(f) and APL 22-005, Contractor must cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;

2) Services are not included in an individual treatment plan;

3) The Member has a co-occurring mental health condition and SUD; or

4) NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Exhibit A, ATTACHMENT III

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

5.6.1 MOU Purpose
5.6.2 MOU Requirements
5.6.3 MOU Oversight and Compliance

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

Memorandum of Understandings (MOUs) entered into pursuant to this Contract and as set forth in All Plan Letters (APLs) are binding, contractual agreements between Contractor and third parties that set forth the responsibilities and obligations of Contractor and a third party, including Local Government Agencies, county programs, and third-party entities, to coordinate and facilitate the provision of Medically Necessary services to Members, sharing data, and as applicable, avoiding the duplication of services where Members are served by multiple parties.

5.6.1 MOU Purpose

Contractor must coordinate with Local Government Agencies (LGAs), county programs, and third-party entities to ensure that Members receive all Medically Necessary services even if those services are not the financial responsibility of Contractor. In circumstances where Contractor is coordinating care and not financially responsible for the care, Contractor must negotiate in good faith and execute a MOU, incorporating all required provisions of this Contract, APLs, and MOU templates and guidance, with the following Local Government Agencies, county program and third-party entities and county programs to ensure Care Coordination, data sharing, and non-duplicative services for Members. Contractor and the LGAs, county programs, and third-party entities may incorporate requirements in addition to any requirements set forth in this Contract or any DHCS issued templates so long as such requirements do not conflict with any required provision. Contractor must use good-faith efforts to consult with persons who have direct experience with Members receiving services from the below programs in the development of the MOU.

A. Contractor must execute MOUs with Local Health Departments (LHDs) in each county within Contractor's Service Area for the following programs and services, at a minimum:

1) California Children's Services (CCS);

2) Maternal and Child Health (MCH);

3) Tuberculosis (TB) Direct Observed Therapy (DOT);

4) For Community Health Worker (CHW) services, as appropriate; and

5) All other Medically Necessary services that are the responsibility of LHDs, not otherwise specified.

B. Contractor must execute MOUs with Women, Infants, & Children (WIC) agencies in each county within Contractor's Service Area.

C. Contractor must execute MOUs with LGAs, such as the County Behavioral Health Department and County Social Services Department, in each county within Contractor's Service Area to assist with coordinating the following programs and services, at a minimum:

1) Specialty Mental Health Services (SMHS);

2) Alcohol and Substance Use Disorder (SUD) treatment services including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS); **and**

~~3) Targeted Case Management (TCM); and~~

~~4~~**3)** In-Home Supportive Services (IHSS).

D. Contractor must execute MOUs to coordinate programs and services for Members with the following LGAs in each county within Contractor's Service Area, at a minimum:

1) Social services; and

2) Child welfare departments.

E. Contractor must execute MOUs to coordinate services provided by Regional Centers (RCs) for persons with Developmental Disabilities in accordance with ~~APL 18-009 and~~ APLs relevant to MOUs, including DHCS issued templates.

F. By July 1, 2024 (or such later date determined by DHCS), Contractor must execute MOUs with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum,Targeted Case Management (TCM).

~~F~~**G**. By January 1, 2025 (or such later date determined by DHCS):

1) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP)

cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).

2) Contractor must collaborate ~~with~~, **and** execute MOUs**,** with **California Department of Corrections and Rehabilitation, county** jails, ~~juvenile~~ **and youth correctional** facilities~~, and probation departments~~.

~~G~~**H**. Contractor must execute MOUs to coordinate programs and services for Members with the following third-party entities in each county within Contractor's Service Area, at a minimum:

1) Home and Community-Based Services (HCBS) program agencies;

2) Continuum of care programs;

3) First 5 programs;

4) Area Agencies on Aging (AAA); and

5) Caregiver Resource Center (CRC).

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a liaison by each party, and notification to the other party of changes to the liaison;

3) Establishment of policies and procedures for eligibility, screening, assessment, evaluation, Medical Necessity determination, and referral systems;

4) Establishment of policies and procedures for coordinating Member care between the parties, including but not limited to, referrals to applicable Enhanced Care Management (ECM), Community Supports and/or community-based resources;

5) Establishment of policies and procedures for the timely and frequent exchange of Member Information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, ~~bi-directional monitoring of data exchange processes,~~ and obtaining Member consent;

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time ~~of~~ the quarterly meeting~~s~~ **occurred,** and, as applicable, distribute to meeting participants a summary of any follow-up action items**,** **changes to processes,** or Corrective Actions that are necessary to fulfill obligations under this Contract and MOU.

8) Contractor must invite other party's executives to participate in quarterly meetings to ~~ensure~~ **facilitate** appropriate committee representation, including local presence, to discuss and address Care Coordination and MOU-related issues.

9) Agreement by both parties, to the extent such non-Contractor party will agree to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;

10) Establishment of policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

11) Establishment of policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;

12) Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU;

13) Establishment of policies and procedures to address emergency preparedness protocols in accordance with Exhibit A, Attachment III, Article 6.0 (*Emergency Preparedness and Response*); and

~~14) Provision requiring third-party entities and county programs to participate in Contractor's Population Needs Assessment (PNA).~~

B. In addition to the MOU requirements listed in Paragraph A of this Subsection, MOUs must contain the following components identified in this Paragraph B, as applicable:

1) MOUs with County Mental Health Plans (MHPs)

a) The requirements contained in Welfare and Institutions Code (W&I) section 14715~~and APL 18-015~~;

b) Policies and procedures for the delivery of SMHS, including the MHP's provision of clinical consultation with Contractor for Members being treated for mental illness;

c) Policies and procedures for the delivery of Medically Necessary Non-specialty Mental Health Services (NSMHS) within the PCP's scope of practice;

d) Policies and procedures for the timely and frequent exchange of Member information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, ~~bi-directional monitoring of data exchange processes,~~ and, if necessary, obtaining Member consent;

e) Policies and procedures for the delivery of Medically Necessary Covered Services to Members who require SMHS, including but not limited to:

i. Prescription Drugs when administered in an outpatient setting and not otherwise excluded under this Contract;

ii. Laboratory, radiological and radioisotope services;

iii. Emergency room facility charges and professional services;

iv. Transportation;

v. Home health services;

vi. Drug Medi-Cal; and

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or IMDs.

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

D. **Executed** MOUs must be publicly posted.

E. MOUs ~~cannot~~**must not** be delegated**, except that Contractor may delegate its obligations under the MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to the MOU**.

5.6.3 MOU Oversight and Compliance

A. MOU Oversight Requirements

Contractor must have processes in place to maintain collaboration among the parties to the MOU and identify strategies to monitor and assess the effectiveness of MOUs as follows:

1) Conduct regular meetings, which include the designated individuals responsible for oversight and performance under the MOU, at least quarterly to address policy and practical concerns that may arise between MOU parties;

2) Resolve conflicts between MOU parties within a reasonable timeframe;

3) Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs and notify DHCS within five Working Days of any change in the designated MOUs' liaison;

4) Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;

5) Provide education and training of MOU as required by Exhibit A, Attachment III, Subsection 5.6.2.A.12) above;

6) If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;

7) Ensure appropriate committee representation ~~including~~ **by inviting a** local presence ~~for~~ **in advance to** each quarterly meeting ~~and the~~ **an** opportunity to discuss and address Care Coordination and MOU-related issues with county executives;

8) Ensure an appropriate level of leadership ~~on~~ **are invited to participate in** MOU engagements from both Contractor and entity **as appropriate**; and

9) Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS through APLs and guidance.

B. MOU Compliance Requirements

1) At a minimum, executed MOUs listed in this Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) must be submitted to DHCS.

2) To the extent Contractor does not execute a~~n~~ MOU within ~~four months of the effective date of this Contract or within~~ the timeframe required under this Contract and relevant APLs, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU and the explanation for why the MOU has not been executed.

3) Contractor, at a minimum, must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

4) Contractor must report on its compliance with the MOU to Contractor's compliance officer at least on a quarterly basis.

Exhibit A, ATTACHMENT III

6.0 Emergency Preparedness and Response (To Become Effective on January 1, 2025)

This Article's provisions, which will become effective on January 1, 2025, make explicit DHCS' commitment to ensuring that the Medi-Cal managed care delivery system is prepared for those unforeseen circumstances that require immediate action. Specifically, Contractors must plan for and ensure continuity of business operations, delivery of essential care and services to Members, and mitigate potential harm caused by Emergencies, such as a natural or manmade disaster or public health crisis. This Article includes provisions requiring that Contractor must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. In addition, during a federal, State, or county declared state of Emergency, Contractor must implement protocols that allow Members timely access to Covered Services including by allowing flexibility for Prior Authorization, pre-certification, and referrals.

6.1 Emergency Preparedness and Response (To Become Effective on January 1, 2025)

6.1.1 General Requirements
6.1.2 Business Continuity Emergency Plan
6.1.3 Member Emergency Preparedness Plan
6.1.4 California's Standardized Emergency Management System
6.1.5 Reporting Requirements During an Emergency
6.1.6 DHCS Emergency Directives

6.1 Emergency Preparedness and Response

6.1.1 General Requirements

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), “Emergency” means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), “Emergency Preparedness” means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor’s Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), “Emergency Preparedness and Response Plan” means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

This Article 6.0 (*Emergency Preparedness and Response*) will not become effective until January 1, 2025. Contractor must immediately comply with all requirements in this Contract relating to this Article 6.0 (*Emergency Preparedness and Response*) set out in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*) upon becoming effective January 1, 2025. Nothing in this Article 6.0 (*Emergency Preparedness and Response*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply, such as any duties or requirements under federal and State laws and regulations relating to Emergency Preparedness.

Contractor must have in place an Emergency Preparedness and Response Plan which includes, at a minimum

A. A Business Continuity Emergency Plan, as described in Exhibit A, Attachment III, Section 6.2 *(Business Continuity Emergency Plan*)*;*

B. A Member Emergency Preparedness Plan, as described in Exhibit A, Attachment III, Section 6.3 *(Member Emergency Preparedness Plan*)*;* and

C. Contractor's policies and procedures for complying with all of the requirements set forth in this Article 6.0 (*Emergency Preparedness and Response*).

Contractor must submit its Emergency Preparedness and Response Plan to DHCS for approval prior to the start of Contractor's operations. Contractor mustsubmit any updates to deliverables identified in this Section to DHCS as requested.

6.1.2 Business Continuity Emergency Plan

Contractor must have a Business Continuity Emergency Plan in place to deal with any Emergency that may affect Contractor's business operations, including, but not limited to, access to Network Providers, Subcontractors, and Downstream Subcontractors; communications; staffing; supplies; and information technology concerns.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Business Continuity Emergency Plan" means a document consisting of the critical information and processes Contractor needs to continue operating during an Emergency.

Contractor must consider the availability of local resources and requirements and, upon request, coordinate with local city and county Emergency Preparedness programs when establishing its Business Continuity Emergency Plan.

At a minimum, Contractor's Business Continuity Emergency Plan must address the following:

A. Communication

Contractor must describe how it will communicate with staff, Network Providers, Subcontractors, Downstream Subcontractors, DHCS, and other essential persons and entities during an Emergency. Contractor must also include how Contractor will provide Member, Network Provider, Subcontractor, and Downstream Subcontractor access to call centers for questions; how Contractor will provide dedicated staff and resources toward the Emergency process; and how Contractor will address the continual and timely resolution of claims. Contractor must maintain Emergency contact information, telephone numbers, and other contact

information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, Network Providers, Subcontractors, Downstream Subcontractors, and other essential persons and entities. Contractor must update this contact information as changes occur, but no less than every six months.

B. Emergency Preparedness Risk Assessment

Contractor must identify and assess potential public health crises and natural or man-made Emergencies, including, but not limited to, epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any location in which Contractor conducts business operations under this Contract. When assessing the risk of a potential Emergency, Contractor must consider the likelihood of the Emergency within its Service Area and how the Emergency may disrupt Contractor’s business operations. Contractor must identify and assess any essential supply chain impacts that may disrupt business operations during or after the Emergency. Contractor must update its assessment as changes occur, but at least on an annual basis.

C. Emergency Team Staffing and Responsibilities

1) Contractor must identify an Emergency team and back-up Emergency team members to carry out Contractor’s Business Continuity Emergency Plan in the event of an Emergency.

2) Contractor must clearly designate the Emergency team’s responsibilities during an Emergency, including, but not limited to, sending out Emergency communications to Contractor’s employees, Network Providers, Subcontractors, Downstream Subcontractors, Members, managing site security staff, those staff responsible for securing utilities, and other essential persons and entities.

3) Contractor must ensure that Emergency team members know how to report their status to the Emergency team during and after an Emergency to keep Contractor informed of changing needs.

D. Cooperative Arrangements

Contractor must attempt to establish cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected. Contractor must submit to DHCS an attestation that it will update its cooperative arrangements at least annually and submit to DHCS.

E. Training and Drills

1) Contractor mustestablish an Emergency training program to train new and existing staff on Contractor's Business Continuity Emergency Plan.

2) Contractor must conduct annual Business Continuity Emergency Plan drills to ensure Emergency Preparedness and to detect vulnerabilities that can be addressed before an actual Emergency arises. Contractor mustsubmit a report to DHCS within 30 calendar days of each training drill which identifies drill activities, provides a summary of outcomes, and creates a plan to address any vulnerabilities found.

3) Contractor must, upon request, participate in mock disaster drills coordinated by governmental entities, if available, to ensure coordination during an Emergency.

4) Contractor must ensure that the equipment and supplies necessary to sustain business operations are readily available in the event of an Emergency.

F. Systems Recovery

1) Emergency Operation

Contractor mustestablish a plan to maintain critical business processes that protects confidential and sensitive electronic and non-electronic information, including, but not limited to, Protected Health Information (PHI), personal information, and claims information during an Emergency.

2) Data Backup

Contractor mustestablish procedures to backup confidential and sensitive electronic information, including, but not limited to, PHI, PI, and claims information to maintain the ability to retrieve such

information during an Emergency. Contractor mustestablish a regular schedule for conducting backup procedures, storing backup information offsite, updating an inventory of backup media, and formulating an estimate for the time needed to restore lost confidential and sensitive information. At a minimum, Contractor mustconduct a full backup process of its confidential and sensitive electronic information on a weekly basis and update its offsite data storage on a monthly basis.

6.1.3 Member Emergency Preparedness Plan

Contractor must establish a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in Long-Term Care facilities, Skilled Nursing Facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Member Emergency Preparedness Plan" means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between Contractor and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency

At a minimum, Contractor's Member Emergency Preparedness Plan must address the following:

A. Member Communication

1) Contractor musthave the ability to set up a Member services call center for communication with Members before, during, and after an Emergency.

2) Contractor mustestablish Emergency protocols for its Member services call center. Protocols must include, but are not limited to, call scripts that account for different Member needs, staff training in crisis response, Contractor Emergency protocols that ensure access to Covered Services, and processes for escalating a call through warm hand-off connections to nurses or doctors for Members needing immediate assistance.

3) During and post-Emergency, Contractor must:

a) Instruct Members about how to reach Contractor's nurse advice line, care coordinators, Medi-Cal Rx pharmacy services, Telehealth services, and other Contractor services and resources as deemed appropriate;

b) Notify Members about available alternative primary pharmacy, dialysis center, chemotherapy or other infusion therapy location, and other treatment sites;

c) Inform Members about how Contractor may modify its care protocols and Member benefits to ensure continued access to Medically Necessary services;

d) Provide Members with information on how to obtain medical authorizations, out-of-Network care, medication refills or Emergency supply, Durable Medical Equipment (DME) and replacements, and Medical Records; and

e) Inform Members about how to access behavioral and mental health services.

B. Continuity of Covered Services

1) Contractor must ensure that Members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services. Contractor must take actions to ensure continued access, including but not limited to the following:

a) Relaxing time limits for Prior Authorization, pre-certification, and referrals;

b) Extending filing deadlines for Grievances and requests for Appeal in accordance with Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

c) Coordinating, transferring, and referring Members to alternate sources of care when Providers are closed, unable to meet the demands of a medical surge, or otherwise affected by an Emergency;

d) Authorizing Members to replace DME or medical supplies out-of-Network;

e) Allowing Members to access appropriate out-of-Network Providers if Network Providers are unavailable due to an Emergency or if the Member is outside of the Service Area due to displacement; and

f) Providing, when directed, a toll-free telephone number for displaced Members to call with questions, including questions about the loss of a Beneficiary Identification Card, access to prescription refills, and how to access health care.

2) Contractor must establish policies and procedures to immediately implement these actions as necessary or as directed by DHCS.

C. Network Provider, Subcontractor, and Downstream Subcontractor Emergency Requirements

1) Education

a) Contractor must educate Network Providers, as a part of training in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*); Subcontractors; and Downstream Subcontractors on Contractor's Emergency policies and procedures.

b) Contractor must provide Network Providers, Subcontractors, and Downstream Subcontractors with an Emergency Preparedness fact sheet and resources on general Emergency Preparedness, response, and communications protocols.

2) Communications During an Emergency

a) Contractor must have a system and process in place to be able to provide and receive information from Network Providers, Subcontractors, and Downstream Subcontractors during an Emergency.

b) Contractor musthave a process in place to inform Network Providers, Subcontractors, and Downstream Subcontractors about what modifications need to be implemented during an Emergency to ensure that Members are able to access Covered Services, and how Contractor can assist Network Providers, Subcontractors, and Downstream Subcontractors in those efforts.

3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System (SEMS).

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor mustnotify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS mustinclude, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

a) The number of Network Provider site closures by Provider type, per county;

b) The number of Members served by each closed Network Provider, per county;

c) The number of hospitalized Members who need to be transferred;

d) The location(s) of where Members were transferred; and

e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives

Exhibit A, Attachment III

7.0 Operations Deliverables and Requirements

To demonstrate the requisite capabilities necessary to execute the obligations of this Contract, DHCS outlines specific deliverables that Contractor must submit to DHCS prior to the implementation of the Contract. This period is considered the Implementation Period at which time DHCS will assess the Medi-Cal managed care plan's readiness to begin operations as a Contractor. These deliverables are identified and set forth in Exhibit A, Attachment II, Section 1.0 (*Operational Readiness Deliverables and Requirements*) of the Contract and the tables that follow that Section.

This Article provides a non-exhaustive list of deliverables required to be submitted by Contractor to the DHCS and/or other entity(ies) throughout the term of the Contract to verify Contractor's continued compliance with Contract requirements. Contractor must submit all required deliverables to DHCS in a complete, accurate, and timely fashion. Contractor must submit all required deliverables to DHCS in an ADA-compliant format if identified in the tables below this section as publicly available. Contractor may be responsible for additional deliverable requirements based on changes in State and federal law and/or DHCS program needs. Contractor must meet any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS. Contractor must use the calendar year to define annual, monthly, and quarterly submission timeframes unless directed otherwise.

In the event Contractor fails to submit any deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Sanctions and Liquidated Damages in accordance with Exhibit E, Section 1.19 (*Sanctions*) and Section 1.20 (*Liquidated Damages*) to Contractor.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0001	Key Personnel Disclosure Form	1.1.2	Annually.		DHCS
D.0114	Medical Director Information	1.1.6	**Attest to DHCS that this has been posted no later than January 1 of each year.**	Posted **in an easily accessible location** on Contractor's **Provider portal** website.	Public
D.0002	Key Personnel Change Notification including CEO, CFO, COO, CMO, Chief Medical Director, Health Equity Officer, Compliance Officer, and Government Relations Person.	1.1.8	~~Within ten calendar days~~ Within 20 calendar days	Contractor must post Medical director contact information on their provider portal website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0003	Monthly Financial Reports	1.2.2	Monthly, no later than 30 calendar days after the close of Contractor's fiscal month.	Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.	DHCS
D.0004	Quarterly Financial Reports	1.2.2	Quarterly, no later than 45 calendar days after the close of Contractor's fiscal quarter.		DHCS
D.0005	Annual Financial Reports	1.2.2	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0006	Annual Forecasts	1.2.2	Annually, no later than 60 calendar days prior to the beginning of Contractor's next Fiscal Year.		DHCS
D.0007	Independent Financial Audit Report	1.2.3	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0008	Medical Loss Ratio Report(MLR)	1.2.5; 1.2.5.H	Annually Timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR ~~Reporting Year~~ **reporting year**; and When there is a retroactive change to the Capitation Payments for a MLR reporting year and a new report needs to be submitted to reflect the change.		DHCS
D.0009	Community Reinvestment Plan	1.2.7	Annually.	Posted on Contractor's website.	DHCS
D.0010	Community Reinvestment Report	1.2.7	Annually.	Posted on Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0115	Compliance Program	1.3.1.A.9)	Annually	On Contractor's website.	DHCS
D.0011	Preliminary Fraud, Waste, and Abuse Reports	1.3.2.D.1)	Within ten Working Days of Contractor's discovery of such Fraud, Waste, or Abuse.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0012	Completed Fraud, Waste, and Abuse Investigation Report	1.3.2.D.2)	Within ten Working Days of completing Contractor's Fraud, Waste, or Abuse investigation.		DHCS
D.0013	Quarterly Fraud, Waste, Abuse Status Report	1.3.2.D.3)	Quarterly, ten Working Days after the close of every calendar quarter.		DHCS
D.0014	Suspended, Excluded, or Ineligible Provider Notification	1.3.4.A.6)	Within ten Working Days of removing a suspended, excluded, or ineligible Provider from its Network.		DHCS
D.0116	Disclosures	1.3.5.C	Within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.		
D.0126	**Overpayment Notification of $25 million or more**	**1.3.6.A**	**Within 60 calendar days of the date the overpayment.**		**DHCS**
D.0131	**Overpayment Notification of any amount related to Fraud, Waste, and Abuse**	**1.3.6.A**	**Within 10 calendar days of the date the overpayment.**		**DHCS**
D.0106	Overpayment Recoveries Report	1.3.6.B	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0015	Encounter Data Reporting	2.1.2	Within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter as required by this Contract or as otherwise agreed upon by DHCS, or as mandated through federal law; Within six Working Days of the end of each month following the month of payment;		DHCS
D.0017	Network Provider Data Reporting	2.1.4	Within ten calendar days following the end of each month		DHCS
D.0018	Program Data Reporting	2.1.5	Within ten calendar days following the end of each month		DHCS
D.0019	Template Data Reporting	2.1.6	On a regular basis, or as mandated through federal law		DHCS
D.0020	Management Information System/Data Audits	2.1.7	No less frequently than once every three years.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0016	Data Corrective Action Plans	2.1.8	Within 15 calendar days from the date of the DHCS written notice to Contractor regarding any deficiencies and problem related to Contractor's data or its Management and Information System (MIS).	DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans, or that have been subject to sanctions due to non-compliance .	DHCS; public
D.0117	Tracking Member Alternative Format Selections	2.1.9	As Requested by Member in accordance with the requirements in All Plan Letter (APL) 22-002		DHCS

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0021	Written summary of Quality Improvement and Health Equity Committee (QIHEC) activities, as well as the QIHEC activities of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.3.D	At least quarterly.	On Contractor's website.	DHCS; Public
D.0022	Quality Improvement and Health Equity Plan	2.2.7	Annually.	On Contractor's website.	DHCS; Public
D.0026	NCQA Health Plan Accreditation and Health Equity Accreditation results	2.2.8	After every NCQA accreditation cycle (every 3 years). Within 30 calendar days of the receipt of the completed report from NCQA Within 15 calendar days of confirmation of the site visit by NCQA		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0024	**Health plan Subcontractor and Downstream Subcontractor quality and health equity performance data**	**2.2.9.A.2**	**Annually (and as requested by DHCS).**		**DHCS**
D.0023	Performance Improvement Project reporting	2.2.9.B	At intervals determined by DHCS. At least annually.	On the DHCS website.	DHCS; Public
D.0025	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results and CAHPS results for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.9.C	Annually after January 1, 2026.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0027	Appeals Procedure	2.3.1.F	As needed when updated.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0028	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a material change as specified by DHCS within 30 calendar days from either the beginning of the annual reporting period or the material change.	On Contractor's website.	DHCS; Public
D.0029	Non-Federally Qualified HMOs Subcontractor Agreement, Downstream Subcontractor Agreement, and Network Provider Amendment Approval Request	3.1.5	At least 30 calendar days before the effective date, unless otherwise instructed by DHCS Within 60 calendar days after the date the overpayment was identified		DHCS
D.0030	Federally Qualified HMOs Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement	3.1.8	Upon DHCS request.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS
D.0118	Provider Selection	3.1.10	Upon request		DHCS
D.0119	Delegation Model	3.1.12		On Contractor's website	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0034	Hospital Inpatient Days Report	3.2.8	As required by Welfare and Institutions Code (W&I) section 14105.985(b)(2) Within 30 calendar days of DHCS' request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0035	Alternative and Value-Based Payment Models Report	3.3.1.B C	Within 90 calendar days of DHCS' request. Annually.		DHCS
D.0036	Financial Incentive Programs Report	3.3.3	As specified by DHCS.		DHCS
D.0037	Identification of Responsible Payor	3.3.4	Upon request and in a manner prescribed by DHCS.		DHCS' fiscal intermediary (FI) contractor
D.0038	Documentation of services for Contractor's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0039	Certification of Terms and Conditions for Network Provider Agreements with FQHCs and RHCs	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0040	FQHC and RHC Network Provider Agreements	3.3.7.B	Whenever any Network Provider Agreements are executed or amended.		DHCS
D.0041	Disputed Emergency Services/Post-Stabilization Care Claims	3.3.16	As needed. Within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim		DHCS - Office of Administrative Hearings and Appeals

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0042	Request to Conduct Activity Outside of Contract Requirements	4.1.2	As needed, at least 30 calendar days prior to the Marketing event.		DHCS
D.0043	Updates to Marketing Representative Training and Certification Program	4.1.1	Prior to implementation.		DHCS
D.0044	Marketing Materials	4.1.2	Prior to distribution. At least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.		DHCS
D.0045	Marketing Plan	4.1.2	Annually. When there are any changes made to Contractor's Marketing plan.		DHCS

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0046	Population Health Management Strategy	4.3.1	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0047	Population Needs Assessment	4.3.2	At least every three years.	On Contractor's website.	DHCS; Public
D.0048	**Managed Care Liaison Change Notification**	**4.3.24**	**Within five days of the change.**		**DHCS**

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0049	Enhanced Care Management Model of Care (MOC)	4.4.5	Contractor must submit to DHCS any Significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0050	Community Supports Model of Care	4.5.5	Contractor must submit to DHCS any changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0051	Receipt of ~~Discrimination~~ **Standard** Grievances	4.6.2.E	Within five calendar days of receipt of the Grievance.		Member who filed a Grievance
D.0052	Discrimination Grievance Information	4.6.3.C	Within ten calendar days of mailing a Discrimination Grievance resolution letter.	On Contractor's website.	DHCS - Office of Civil Rights;
D.0053	Sample Notice of Action (NOA) Letter	4.6.4.C 4.6.4.E .3	Within 30 calendar days from receipt of information that is reasonably necessary to make a determination. No later than 60 calendar days from the date on the NOA		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0054	Grievance Logs	4.6.9	Upon DHCS request. ~~Monthly.~~		DHCS and/or CMS

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
~~D.0055~~	~~Member Information Notice~~	~~5.1.3~~	~~Prior to use.~~		~~DHCS~~
D.0056	Nondiscrimination Notice and Language Taglines	5.1.3	Prior to use.	On Contractor's website – accessible from Contractor's home page.	DHCS
D.0057	Member Information - Provider Directory	5.1.3	Prior to initial Operations; Monthly; Every six months; and When ontractor updates the Provider Directory. One week after Contractor receives updated provider information.	On Contractor's website.	DHCS; Public
D.0058	Member Information - Member Handbook/Evidence of Coverage (EOC)	5.1.3	Before distribution to Members; When updated; or Other timeframes provided by DHCS.	On Contractor's website.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0129	**EOC Attestation- Notification to DHCS that the EOC has been mailed and/or posted on the ~~MCP~~Contractor's Website.**	**5.1.3**	**Annually, by January 1.**	**On Contractor's website**	**DHCS**

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0059	Alternative Access Standard Requests	5.2.5	At least annually and when Contractor is unable to comply with the time or distance standards set forth in W&I section 14197.04.	Contractor's website for Contractor specific results and the DHCS website with statewide results.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0060	Network and Access Changes to Covered Services	5.2.9.A	When Contractor discovers a Provider-initiated termination impacting more than 2,000 Members; When Contractor discovers a Provider-initiated termination that affect Contractor's ability to meet network adequacy standards; When there is a change in the availability or location of Covered Services; and Within ten calendar days of Contractor discovering a Provider's exclusionary status from any database or list.		DHCS
D.0061	Notification regarding Community Based Adult Services (CBAS) Network Provider	5.2.9.A	When Contractor is unable to contract with a certified CBAS Provider; Upon termination of a CBAS Network Provider Agreement; and Within five Working Days of Contractor's decision to exclude a CBAS Provider from its Network.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0062	Notification regarding Long-Term Care (LTC) Network Provider	5.2.9.A.4	Within 60 calendar days of termination of a LTC Provider; Immediately if the termination is a result of LTC Provider decertification by CDPH; and Within 72 hours of applicable termination of a LTC Provider.		DHCS
D.0063	Member Notice regarding Provider Termination	5.2.9.B	Prior to its release to Members.		DHCS
D.0064	Community Advisory Committee (CAC) Demographic Report	5.2.11	Annually, by April 1st.		DHCS
D.0065	CAC meeting notices	5.2.11	30 days prior to each quarterly CAC meeting, but in no event later than 72 hours prior to each meeting.	On Contractor's website.	Public
D.0066	CAC meeting minutes	5.2.11.E.3)d)	No later than 45 calendar days after each quarterly meeting.	On Contractor's website.	DHCS; Public
D.0067	Network Certification Report	5.2.13	At least annually	On the DHCS Website.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0068	Notification of Significant Change to Network	5.2.13.B	Any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services.		DHCS
D.0069	Network Change Report	5.2.13	30 calendar days following the end of the reporting quarter.		DHCS
D.0112	Subcontractor and Downstream Subcontractor Certification Report	5.2.13	At least annually, if applicable.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0070	Report of Drug Use Review (DUR) Program Activities	5.3.7.H	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0072	CBAS Member Enrollment Report	5.4.3.A	On a quarterly basis		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0113	Summary of CBAS Complaints	5.4.3.C	30 calendar days following the end of the reporting period.		DHCS
D.0073	CBAS Grievance and Appeal Reports	5.4.3.D	30 calendar days following the end of the reporting period.		DHCS
D.0120	CBAS Provider List	5.4.3.E	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0130	**Revised MOU Template**	**5.6.1.C.2**	**As needed**	**After execution**	**DHCS**
D.0128	**MOU Public Posting**	**5.6.2.D**	**Upon completed execution of contract**	**Executed MOUs must be publicly posted**	**Public and DHCS**
D.0075	Status Report	5.6.3	Quarterly, beginning four months after the effective date of this Contract or within the timeframe required under this Contract and relevant APL, until all required MOUs are executed.		DHCS
D.0127	**MOU Liaison Change Notification**	**5.6.3.A.3**	**Within five Working Days of any change in the designated MOUs' liaison**		**DHCS**

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0121	Existing MOU	5.3.6.A.6	Within ten Working Days of receipt of the request;		DHCS
D.0076	Copy of Executed MOUs	5.6.3	Upon execution, modification or renewal.	On Contractor's website.	DHCS
D.0077	MOU Review Report	5.6.3.B	Annually.		DHCS, upon request

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0078	Emergency Preparedness and Response Plan	6.1	Prior to the start of Operations.	On Contractor's website.	DHCS
D.0079	Emergency Contact Information Update	6.2.A	No less than every six months; and As changes occur.		DHCS
D.0080	Cooperative Agreements	6.2.D	At least annually.		DHCS
D.0081	Emergency Drill Report	6.2.E	Within 30 calendar days after the drill is completed.		DHCS
D.0082	Member Emergency Preparedness Plan Templates	6.3	Prior to use for each mode of communication. This deliverable is not required until 2025.		DHCS
D.0083	Daily Emergency Reporting	6.5.B	Once a day, at a minimum, throughout the State of Emergency.		DHCS

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0084	Supplemental Payments Report	**1.**1.7.A	**On a** ~~M~~**m**onthly **basis by**~~,~~ no later than ~~the~~ 20~~th~~ calendar day**s** following the end of each month.		DHCS
D.0085	Supplement Payment Eligibility Data	**1.**1.7.A	**Contractor must properly submit all required data to DHCS** ~~W~~**w**ithin ~~14~~ **12** months of the month of the service entitling Contractor to a Supplemental Payment.		DHCS
D.0086	Additional Payments Report	**1.**1.8.A	**On a** ~~M~~**m**onthly **basis**, no later than ~~the~~ 20~~th~~ calendar day**s** following the end of each month.		DHCS
D.0087	Additional Payments Report Eligibility Data	**1.**1.8.A	**Contractor must properly submit all required data to DHCS** ~~W~~**w**ithin ~~14~~ **12** months of the month of the service entitling Contractor to an additional payment.		DHCS
D.0122	Financial Performance Guarantee	**1.**1.12	Annually.		DHCS
D.0088	Medical Loss Ratio Remittance	**1.**1.15	When the ratio for the MLR reporting year does not meet the minimum MLR standard.		DHCS

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables or requirements listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
~~D.0089~~	~~List of Equipment/ Property for State to Procure~~	~~3.d.1~~	~~When Contractor needs to secure equipment/property above the annual maximum limit of $50,000.~~		~~DHCS~~
~~D.0090~~	~~State Equipment and/or Property Inventory Report~~	~~4.a.2~~	~~Annually.~~		~~DHCS~~
~~D.0091~~	~~State Equipment and/or Property Theft Report~~	~~4.d~~	~~In the event of State equipment and/or property theft.~~		~~DHCS~~
~~D.0092~~	~~Final Inventory Report of State Equipment and/or Property~~	~~4.e~~	~~Within 60 calendar days prior to the termination or end of this Contract.~~		~~DHCS~~
~~D.0093~~	~~Automobile Liability Insurance~~	4	~~When any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Contract.~~		~~DHCS~~
D.0094	Request for Subcontract Authorization	5.a	Before Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more.		DHCS
~~D.0095~~	~~Prior Approval of Training Seminars, Workshops or Conferences~~	~~13~~	~~As applicable, prior to the event.~~		~~DHCS~~

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0096	Requests for Disclosure of Confidential Information	14	As applicable.		DHCS
D.0097	Contractor Certification of Federal Fund Expenditure	17	As applicable.		DHCS
D.0098	Financial and Compliance Audit Reports	17.d	Within 30 calendar days after the completion of the audit.		DHCS
D.0099	Contractor Explanation for Debarment and Suspension Certification.	20	As applicable.		DHCS

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0123	Certifications - Data, Information, and Documentation Submitted to DHCS	1.11	Monthly		DHCS
D.0100	Contractor's Analysis regarding its financial solvency	1.16	As needed.		DHCS
D.0101	Contractor Termination Notice due to financial insolvency	1.16	As needed, and at least six months prior to expected effective termination date.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0124	Phaseout Transition Requirements	1.17.B	Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area		DHCS
D.0102	Notice of Dispute	1.21.B	Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor.		DHCS
D.0103	Costs Avoidance Reports	1.25	Within ten calendar days of discovery By the 15th day of each month		DHCS
D.0104	Post-Payment Recovery Report	1.25.H 1.25.J	At the tenth day of each month; and Within ten calendar days of discovery when Contractor identifies OHC unknown to DHCS.		DHCS
D.0105	Service and Utilization Information	1.26	Within 30 calendar days of the DHCS' request.		DHCS
D.0125	Litigation Support Records	1.27.A	Upon DHCS request.		DHCS
D.0107	DVBE Reporting Requirements	1.31	60 calendar days after receiving final payment, if Contractor made a commitment to achieve DVBE participation.		DHCS

EXHIBIT F, CONTRACTOR'S RELEASE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0108	Contractor's Release	F	With the submission of final invoice(s).		DHCS

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0109	Notice to DHCS of Breaches and Security Incidents	18.1	See contract language for details.		DHCS
D.0110	Completed Final Privacy Incident Reporting Form	18.3	Within ten Working Days of the discovery of the security incident or breach.		DHCS

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0111	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a change as specified by DHCS within 30 calendar days following the annual reporting period or the material change	On Contractor's website.	DHCS; Public

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables or requirements listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit B – Budget Detail and Payment Provisions

1.0 Budget Detail and Payment Provisions

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause
1.1.2 Contractor Risk
1.1.3 Capitation Payment Rates
1.1.4 Capitation Payment Rates Constitute Payment in Full
1.1.5 Determination and Redetermination of Capitation Payment Rates
1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes
1.1.7 Supplemental Payments
1.1.8 Additional Payments
1.1.9 Recovery of Amounts Paid to Contractor
1.1.10 Reinsurance
1.1.11 Catastrophic Coverage Limitation
1.1.12 Financial Performance Guarantee
1.1.13 Medicare Coordination
1.1.14 Special Contract Provisions Related to Payment
1.1.15 Medical Loss Ratio Remittance
1.1.16 State Program Receiving Federal Financial Participation
1.1.17 Community Reinvestment
1.1.18 Quality Achievement Requirement
1.1.19 Enhanced Care Management Risk Corridor
1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor
1.1.21 Unsatisfactory Immigration Status Risk Corridor

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Section **1.**1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment Rates

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. For the list of aid codes included in each Rate Group below, please see the definition of Potential Member

set forth in Exhibit A, Attachment I, Section 1.0 (*Definitions*) of this Contract. Supplemental and Additional Payments listed below will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

For the period ~~01/01/2024 – 12/31/2024~~January 1, 2024 – December 31, 2024	**Orange**
Aid Group	**Rates**
Adult/Family/OTLIC Under 19 - SIS	$179.11
Adult/Family/OTLIC Under 19 - UIS	$90.98
Adult/Family/OTLIC 19 & Over - SIS	$383.42
Adult/Family/OTLIC 19 & Over - UIS	$292.96
SPD - SIS	$1,218.81
SPD - UIS	$720.29
BCCTP - SIS	$1,218.81
BCCTP - UIS	$720.29
SPD Dual - SIS	$553.47
SPD Dual - UIS	$142.04
LTC - SIS	$1,218.81
LTC - UIS	$720.29
LTC Dual - SIS	$553.47
LTC Dual - UIS	$142.04
Adult Expansion - SIS	$430.93
Adult Expansion - UIS	$358.72
WCM - SIS	$2,236.05
WCM - UIS	$596.70

For the period ~~01/01/2024 – 12/31/2024~~January 1, 2024 – December 31, 2024	**Orange**
Supplemental and Additional Payment Groups	**Rates**
Maternity - SIS	$8,811.73
Maternity - UIS	$8,811.73
Adult Expansion Maternity - SIS	$8,811.73
Adult Expansion Maternity - UIS	$8,811.73

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for Members in the new aid code. DHCS must confirm all aid code splits and the rates of

payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

C. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates must be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by Centers for Medicare & Medicaid Services (CMS), said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

1.1.4 Capitation Payment Rates Constitute Payment in Full

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

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1.1.5 Determination and Redetermination of Capitation Payment Rates

A. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS must establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

1) DHCS must establish Capitation Payment rates in accordance with W&I section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

2) DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

3) If Contractor delegates financial risk for the provision of Covered Services in accordance with Exhibit A, Attachment III, Subsection 3.1.6 (*Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers*), DHCS reserves the right,

subject to actuarial judgment and generally accepted actuarial principles and practices, to consider the actual payments received by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates

B. Capitation Payment rates must be effectuated through an amendment or change order to this Contract in accordance with Exhibit E, Subsection 1.1.6 (*Amendment and Change Order Process*) of this Contract, subject to the following provisions:

1) The amendment or change order shall be effective as of January 1 of each year covered by this Contract;

2) In the event there is any delay in a determination or redetermination of Capitation Payment rates so that an amendment or change order may not be processed in sufficient time to permit payment of new rates commencing January 1, payment to Contractor shall continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the Capitation Payment rates and the time period for which these rates will be applied. The R Letter must not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification providing for the rate change, DHCS must make retroactive adjustments for those months for which interim payment was made;

3) By accepting payment of new Capitation Payment rates prior to approval by CMS of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by DHCS must be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

b) Unless otherwise required by CMS, any overpayment to Contractor must be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent

of Contract Revenues for each month until any overpayment is fully recovered by the State; and

c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

4) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor shall have the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in Exhibit E, Subsection 1.1.16 (*Termination*) of this Contract. DHCS must pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

5) DHCS must make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this provision or Exhibit B, Subsection 1.1.6 (*Redetermination of Capitation Payment Rates Due to Obligation Changes*) below prior to implementation of any new rates.

1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I section 14301.1, to Contractor. Any adjustments must be effectuated through an amendment or change order to the Contract subject to the following:

A. The amendment or change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

B. In accordance with Subsection 1.1.5 *(Determination and Redetermination of Capitation Payment Rates*) of this Exhibit B, in the event DHCS is unable to process the amendment or change order in sufficient time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor must continue at the rates then in effect. Upon final approval of the amendment or change order, DHCS must make adjustments for those months in which interim payments were made; and

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Subsection 1.1.16 (*Termination)* of this Contract, in the event a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

1.1.7 Supplemental Payments

A. Contractor shall be entitled to Supplemental Payments stated within this Section in accordance with the schedule of Supplemental Payment rates set forth in this Exhibit B, Subsection 1.1.3 (*Capitation Payment Rates*). Contractor must maintain evidence of payment for qualified services entitling Contractor to Supplemental Payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of Supplemental Payments paid to Contractor..

1) On a monthly basis, by no later than 20 calendar days following the end of each month, and in a format specified by DHCS, Contractor must submit a report for Supplemental Payments. This report must identify the Members receiving services qualifying for a Supplemental Payment and for whom Contractor is claiming payment.

2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within ~~14~~ **12** months of the month of the service entitling Contractor to a Supplemental Payment.

B. **Maternity Supplemental Payments**

1) Contractor shall be entitled to receive maternity Supplemental Payments for Members enrolled with Contractor on the date of the delivery of a Child, including retroactive Enrollments.

2) The maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

1.1.8 Additional Payments

A. Contractor shall be entitled to additional payments stated within this Section in accordance with the schedule of additional payment rates set forth below. Contractor must maintain evidence of payment for qualified services entitling Contractor to additional payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of additional payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month and in a format specified by DHCS, Contractor must submit a report for additional payments. This report must identify the Members receiving services qualifying for any additional payment and for whom Contractor is claiming payment.

2) To be eligible to receive an additional payment, Contractor must properly submit all required data to DHCS within ~~14~~ **12** months of the month of the service entitling Contractor to an additional payment.

B. Contractor shall be entitled to receive an IHCP payment for Members qualified to receive services in accordance with Exhibit A, Attachment III, Subsection 3.3.7.C (*Indian Health Care Providers*) of this Contract.

1) DHCS will annually publish the IHCP payment rates via an All Plan Letter (APL).

2) The IHCP payment reimburses Contractor for the amount paid to the IHCPs as required in Exhibit A, Attachment III, Subsection 3.3.7 *(Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract. Payments must be based on Member utilization of qualifying services at IHCPs as reported by Contractor.

1.1.9 Recovery of Amounts Paid to Contractor

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances:

A. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor’s Medi-Cal managed care health plan, a Member’s residence is outside of Contractor's Service Area, or, pursuant to 22 California Code of Regulations (CCR) section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor must inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

B. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor’s Medi-Cal managed care health plan, but should have been retroactively disenrolled in accordance with Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor must provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract;

C. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS by imposing an offset to Contract Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request; and

D. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS must notify Contractor of the improper or erroneous nature of the payment, and must describe the recovery process. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

1.1.10 Reinsurance

In accordance with 22 CCR section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

A. Reinsurance must not reduce Contractor’s liability below $5,000 per Member for any one 12-month period.

B. Reinsurance may cover both of the following:

1) The total cost of services provided to Members under emergency circumstances by non-contracted Providers, including the cost of inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

2) Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

C. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

1.1.11 Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this catastrophic coverage limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be

determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the amount to DHCS for each day in of the month after the Director's invocation of this catastrophic coverage limitation.

1.1.12 Financial Performance Guarantee

A. In accordance with 22 CCR section 53865, Contractor must annually provide satisfactory evidence of, and maintain, a Financial Performance Guarantee in the form specified by DHCS and in an amount of at least one million dollars ($1,000,000) or equal to at least one month's Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues calculated for the previous twelve months of Contractor's operation, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, and subject to approval by DHCS. In its discretion, DHCS may increase the required amount of the Financial Performance Guarantee for Contractor up to an amount of two million dollars ($2,000,000) or equal to two months' Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues for the previous twelve months, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, for any material breach of this Contract.

B. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis, subject to DHCS approval.

C. DHCS shall take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms in this Contract. Unless DHCS has a financial claim or offset against Contractor in which case DHCS may immediately enforce its rights under the Financial Performance Guarantee, the Financial Performance Guarantee shall remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

1.1.13 Medicare Coordination

In accordance with 42 CFR section 438.3(t), Contractor must enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and must agree to participate in Medicare's automated claims crossover process for full benefit dual eligible Members.

1.1.14 Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each of the following applicable Pass-Through Payments established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance:

1) ~~Hospital Quality Assurance Fee (HQAF)~~ **Private Hospital** and District and Municipal Public Hospital (DMPH) Pass-Through Payments, which requires Contractor to make increased payments to private hospitals and DMPHs in accordance with DHCS guidance.

2) Martin Luther King Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.

3) Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.

4) Distinct Part Nursing Facilities Pass-Through Payment, which requires Contractor to make increased payments to select publicly owned hospitals in accordance with DHCS guidance.

B. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are

subject to change in accordance with the requirements of 42 CFR section 438.6(c), and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program **(EPP),** which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with ~~the~~ DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

3) District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible DMPHs for every qualifying service in accordance with ~~the~~ DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

4) DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

5) DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

6) Directed Payments for Developmental Screening Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS guidance, including but not limited to APL 23-016, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).

7) Proposition 56 Directed Payments for Physician Services, which requires Contractor to make uniform dollar increase payments to

eligible Network Providers for every adjudicated claim for specified physician services in accordance with DHCS guidance, including but not limited to APL 23-019 and the Directed Payment Initiative preprint.

8) Directed Payments for Adverse Childhood Experiences **(ACEs)**, which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ~~adverse experiences~~ **ACEs** screening services in accordance with DHCS guidance, including but not limited to APL 23-017, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(4).

9) Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008 and the Directed Payment Initiative preprint.

10) Organ and Bone Marrow Transplants, which requires Contractor to pay eligible contracted and non-contracted Providers ~~at exactly~~**amounts equivalent to** the California Medicaid State Plan approved rates**, or amounts equivalent to the rates published by DHCS for University of California system facilities furnishing subject services**, for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance, including but not limited to APL 21-015, the Directed Payment Initiative preprint, and W&I section 14184.201(d).

11) LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services . In all other counties, it requires Contractor~~s~~ to pay Network Providers at no less than the California Medicaid State Plan approved ~~case or service~~ rates for SNF services and ICF/DD, ICF/DD-H, and ICF/DD-N services and Subacute (adult and pediatric) services at minimum. All payments must be made in accordance with DHCS guidance, including but

not limited to APL 23-004, the Directed Payment Initiative preprint, and W&I section 14184.201(b) – (c).

12) Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS through APLs or other guidance, the Directed Payment Initiative preprint, and W&I section 14126.024.

13) In accordance with W&I section 5961.4(c), and for applicable dates of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

14) Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices ~~(~~that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services to ~~Medi-Cal~~ Members~~) in~~ based on DHCS' evaluation of Provider performance on specified quality measures in accordance with the Directed Payment Initiative preprint and in a form and manner specified by DHCS through APLs or other guidance.

15) Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified primary care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and non-specialty mental health services, in accordance with W&I Section 14105.201, any applicable Directed Payment Initiative Preprint, and in a form and manner specified by DHCS through APLs or other guidance.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. ~~For~~

~~applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at https://www.dhcs.ca.gov.~~

D. Contractor must comply with the terms of any applicable Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website~~ at https://www.dhcs.ca.gov.~~. Incentive Arrangement payments must not exceed 105 percent of the approved Capitation Payments attributable to the Enrollees or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation Payments. Incentive Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangements include:

1) California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program, through which Contractor may earn incentive payments for achievement of specified CalAIM Incentive Payment Program milestones and metrics associated with implementation of CalAIM initiatives as determined by DHCS and in accordance with DHCS guidance, including but not limited to the CalAIM Incentive Payment Program terms specified on the DHCS website ~~https://www.dhcs.ca.gov,~~ APL 23-003, and W&I section 14184.207.

2) Student Behavioral Health Incentive Program (SBHIP), through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with targeted interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers as determined by DHCS and in accordance with the terms on the DHCS website ~~https://www.dhcs.ca.gov~~, W&I section 5961.3, and **APL 23-035** ~~in a form and manner specified by DHCS through APLs or other guidance~~.

3) **The Quality Withhold and Incentive Program, which consists of a Withhold Arrangement as described in Paragraph E below, and an Incentive Arrangement through which Contractor may earn incentive payments for achievement of certain targets associated with quality scoring from Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) related data, as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified through APLs or other guidance.**

E. Contractor must comply with the terms of any applicable Withhold Arrangement approved by CMS under 42 CFR section 438.6(b)(3), in a form and manner specified by DHCS through APLs or other guidance. For applicable Rating Periods, DHCS will make the terms of each approved Withhold Arrangement available on the DHCS website.

1) **The Withhold Arrangement must ensure that the Capitation Payment, minus any portion of the withhold that is not reasonably achievable, is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, will take into consideration the financial operating needs accounting for the size and characteristics of the populations covered under this Contract, as well as Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.**

2) **Current Withhold Arrangements include the Quality Withhold and Incentive Program, which consists of an Incentive Arrangement as described in this Paragraph E, and a Withhold Arrangement through which Contractor may earn back the entire Capitation Payment withheld, or portion thereof, for achievement of certain targets associated with quality scoring from HEDIS® and CAHPS ® related data, as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified in APLs or other guidance.**

1.1.15 Medical Loss Ratio Remittance

In accordance with W&I section 14197.2(c)(1), Contractor must provide a remittance to DHCS for a Medical Loss Ratio (MLR) reporting year if the MLR reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) for that MLR reporting year does not meet the minimum MLR standard of 85 percent. DHCS must validate Contractor's reported remittance amount pursuant to Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.1.16 State Program Receiving Federal Financial Participation

Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must cease its work on the part no longer authorized by law after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

1.1.17 Community Reinvestment

A. Contractor must demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community*

Reinvestment Plan and Report). This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS. The percentage of Contractor's annual net income required to be contributed must be:

1) 5 percent of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year; and

2) 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent of Contract Revenues for the year.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require all of its Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors to demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income under the Fully Delegated Subcontractor's Subcontractor Agreement or Downstream Subcontractor's Downstream Subcontractor Agreement that is attributable to Members covered under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS. The percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income required to be contributed must be:

1) 5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is less than or equal to 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year; and

2) 7.5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is greater than 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year.

1.1.18 Quality Achievement Requirement

If Contractor does not meet quality outcome metrics as defined through an APL or similar guidance, it must contribute an additional 7.5 percent of its annual net income under this Contract to community reinvestment in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*).

1.1.19 Enhanced Care Management Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2022, through December 31, 2024.

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the Federally Qualified Health Center (FQHC) Alternative Payment Model (APM) is in effect in accordance with W&I section 14138.16.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.21 Unsatisfactory Immigration Status Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2024, through December 31, 2024.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Unsatisfactory Immigration Status (UIS) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and

the State for those capitation increments, services, and populations associated with UIS, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the UIS risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the UIS risk corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) ("Exhibit C") is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60,

"Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. Government and public entities (including State colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. **Nonprofit organizations and commercial businesses,** whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the

terms of this Agreement be considered State equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.
   (1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

   Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and, at that time, query DHCS as to the requirements, including the manner and method, of returning State equipment and/or property to DHCS. Final disposition of equipment and/or property be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of State equipment and/or property for performance of work under a different DHCS agreement.

f. **Motor Vehicles**

   (Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

   (1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
   (2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
   (3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay

premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

   (1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.
d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.
e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.
h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

   "(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."
i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.
j. Contractor, as applicable, advise all subcontractors of their obligations pursuant

to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.
b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.
c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.
d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.
   (1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor provide and require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. Ownership

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this

Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, include DHCS' notice of copyright, which read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions contain a similar audio notice of copyright.

d. **Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this

Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such thirdparty based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without

restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. **Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution.

The Contractor acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts

relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of State law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization*** and expends $750,000 or more in federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending federal awards received directly from federal awarding agencies, or

(b) The Contractor is a subrecipient expending federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State rely on those audits and any additional audit work and build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or State auditors have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or State auditors review and have access to the current audit work being

conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

19. Novation Requirements

If the Contractor proposes any novation agreement, DHCS act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

20. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR Part 180, 2 CFR Part 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

   (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

   (2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in

connection with obtaining, attempting to obtain, or performing a public (federal, State or local) violation of federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (federal, State or local) terminated for cause or default.

(5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

(6) not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

(7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the

provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the work place.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

23. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

24. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

25. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation not be a public record and remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. “Four Digit Date compliant” Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

28. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

29. Use of Disabled Veteran’s Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Military and Veterans Code Section 999 et seq. in that should award of this contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Military and Veterans Code section 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the Department of General Services (DGS) prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

(1) A written explanation of the reason for the DVBE substitution.

(2) A written description of the business enterprise that will be substituted, including its DVBE certification status.

(3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Military and Veterans Code § 999.9; Public Contract Code (PCC) §10115.10, or PCC §4110 (applies to public works only).

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), al of the following: .

(1) The total amount the prime contractor received under the agreement;

(2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

(3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;;

(4) That all payments under the Contract have been made to the DVBE(s); and

(5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, the Department will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in Section 999 of the Military &

Veterans Code, including, but not limited to, the requirements of Section 999.5(d). (PCC§ 10230.)

30. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No State funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee account for State funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee , where State funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no State funds were used for those expenditures, and that Grantee provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one’s employer to an employee in addition to one’s regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director’s and executive committee member’s fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, <u>cannot</u> be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Compliance with Statutes and Regulations

a. The Contractor comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part 431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement incorporate the contractual provisions in these federal regulations and they supersede any conflicting provisions in this Agreement.

37. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification

Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension,

continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, or cooperative agreement, the undersigned complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

3. The undersigned require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

<table>
<tr><td colspan="2">1. Type of Federal Action:</td><td colspan="2">2. Status of Federal Action:</td><td colspan="2">3. Report Type:</td></tr>
<tr><td>_</td><td>a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance</td><td>_</td><td>a. bid/offer/application
b. initial award
c. post-award</td><td>_</td><td>a. initial filing
b. material change
For Material Change Only:
Year ___ quarter
date of last report ___.</td></tr>
</table>

<table>
<tr><td>4. Name and Address of Reporting Entity:</td><td>5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:</td></tr>
<tr><td>☐Prime ☐Subawardee
Tier ___, if known:

Congressional District, If known:</td><td>

Congressional District, If known:</td></tr>
<tr><td>6. Federal Department/Agency</td><td>7. Federal Program Name/Description:</td></tr>
<tr><td></td><td>CDFA Number, if applicable:</td></tr>
<tr><td>8. Federal Action Number, if known:</td><td>9. Award Amount, if known:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>10.a. Name and Address of Lobbying Registrant
(If individual, last name, first name, MI):</td><td>b. Individuals Performing Services
(including address if different from 10a.
(Last name, First name, MI):</td></tr>
<tr><td></td><td></td></tr>
</table>

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.

Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
1.1.6 Amendment and Change Order Process
1.1.7 Delegation of Authority
1.1.8 Authority of the State
1.1.9 Fulfillment of Obligations
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1.1.11 Certifications
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1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions
1.1.37 Data Sharing

Exhibit E – Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law

A. Contractor must comply with all applicable federal and State law.

B. All Contract disputes and determinations must be decided under California law.

C. The venue and forum for any action involving a Contract dispute will be in Sacramento County State court.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) (and its implementing regulations (22 California Code of Regulations (CCR) section 1000, *et seq*.) must comply with all applicable provisions of the KKA.

2) A Contractor who is not licensed to operate as a health care service plan pursuant to the KKA must perform all acts and satisfy all requirements under the KKA to the same extent as Contractors who are licensed pursuant to the KKA, except as otherwise expressly provided in this Contract. A Contractor who is not licensed to operate as a health care service plan under the KKA is not required by this Contract to perform or satisfy the following:

a) Any provision of the KKA which requires the submission of a report of any kind to the Department of Managed Health Care (DMHC) or obliges a health care service plan to seek approval from DMHC, including, but not limited to, the Independent Medical Review processes set out in section 1370.4 and Article 5.55 of the KKA;

b) Any provision under Article 3 of the KKA related to licensure; and

c) The provisions set forth in Exhibit K of this Contract. Exhibit K is not an exhaustive or exclusive list, and other provisions of the KKA may also be excluded from the Contract pursuant

to this Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of this Contract.

3) Both KKA-licensed Contractors and non-KKA-licensed Contractors are subject to the following provisions:

a) Nothing in this Exhibit E, Subsection 1.1.1 (*Governing Law*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply; and

b) In the event that a provision of this Contract sets a standard or requirement that is higher, or affords a greater benefit or right to a Member than that which the KKA provides, the Contract provisions prevail.

1.1.2 DHCS Guidance

Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual.

A. APLs and PLs

Contractor must comply with all existing and future APLs and PLs as follows:

1) APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein;

2) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide clarification of existing contractual obligations;

3) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation; and

4) APLs and PLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of regulations will have the same force and effect as regulations and may set forth new obligations.

5) APLs and PLs cited and incorporated by reference into the Contract also include any subsequent revisions to the APL or PL.

B. California Medicaid State Plan

Unless otherwise specified in this Contract, Contractor will comply with all applicable provisions of the California Medicaid State Plan, as amended. In the event there is a conflict between the California Medicaid State Plan and this Contract, the California Medicaid State Plan will control. The California Medicaid State Plan and any amendments thereto, can be viewed at the California's Medicaid State Plan (Title XIX) web page.

C. Medi-Cal Provider Manual

Unless otherwise specified in this Contract, Contractor must comply with all current and applicable provisions of the Medi-Cal Provider Manual. In the event that the Medi-Cal Provider Manual conflicts with this Contract, APLs and PLs, and/or any applicable federal or State laws, the Contract, the APL or PL, or the applicable law will control. The Medi-Cal Provider Manual can be viewed online.

1.1.3 Contract Interpretation

A. Conflict with Law

Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it and will be binding on Contractor even though such amendment may not yet have been put in writing, formally agreed upon, and executed by Contractor and DHCS.

If changes in federal or State law result in a material change to the Contract, the amendment may constitute grounds for termination of this Contract in accordance with Exhibit E, Subsection 1.1.16 (*Termination*). The parties will be bound by the terms of the amendment until the effective date of the termination.

B. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers will each be deemed to include the other; (b)

the masculine, feminine, and neuter genders will each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

C. Ambiguities

If it is necessary to interpret the text of this Contract to address potential ambiguities, all applicable laws may be used as aids in interpreting the Contract. However, DHCS and Contractor agree that any such applicable laws will not be interpreted to create additional contractual obligations upon either DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties will be deemed authors of this Contract.

D. Unenforceable Provisions

In the event that any provision of this Contract is unenforceable or held to be unenforceable, then DHCS and Contractor agree that all other provisions of this Contract have force and effect and will not be affected thereby.

E. Timeliness

Time is of the essence in this Contract.

F. Entire Agreement

This written Contract, any amendments thereto, and DHCS guidance as identified in Exhibit E, Subsection 1.1.2 (*DHCS Guidance*), will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.1.4 Assignments, Mergers, Acquisitions

Contractor is prohibited from assigning this Contract, either in whole or in part, without the express written consent of DHCS in the form of a formal written amendment signed by DHCS, Contractor, and the third-party assignee (See also, Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor*

Agreements). Contractor must also obtain the express written consent of DHCS prior to entering into a merger or acquisition, whether or not Contractor is the merging party or the acquiring party.

1.1.5 Independent Contractor

Contractor and their employees and agents, in the performance of this Contract, will act in an independent capacity and not as officers or employees or agents of DHCS.

1.1.6 Amendment and Change Order Process

A. General Provisions

The parties recognize that during the term of this Contract, the Medi-Cal managed care program is a dynamic program requiring ongoing changes to its operations and that the scope and complexity of changes will vary widely over the term of this Contract. Contractor must develop a system which has the capability to implement such changes in an orderly and timely manner. This is an essential contract performance obligation.

B. Proposal of Contract Changes

Except for required amendments pursuant to Exhibit E, Section 1.3.A (*Conflict with Law*) should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

1) Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment prior to the language being finalized and submitted to CMS for approval.

2) DHCS will determine Contractor’s Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Subsection 1.1.5 (*Determination and Redetermination of Capitation Payment Rates*).

C. Implementation of Contract Changes

DHCS may, at any time within the general scope of this Contract and by written notice, implement amendments or issue change orders to the Contract upon approval from CMS, as follows:

1) Capitation Payment rates may be implemented through a change order if the rates are the only changes proposed by DHCS for a Rating Period.

2) Capitation Payment rates that are also tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment, or issues a change order or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement

this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an AR through written notice to the DHCS Contracting Officer. Contractor's Representative will be empowered to legally bind Contractor to all agreements reached with DHCS.

Contractor will designate Contractor's Representative in writing and must notify the DHCS Contracting Officer in accordance with Exhibit E, Subsection 1.1.12 (*Notices*).

1.1.8 Authority of the State

A. Subject to federal and State laws and regulations, DHCS has sole authority to establish, define, and determine the reasonableness, necessity, level, and scope of Covered Services available under the Medi-Cal managed care program administered through this Contract or coverage for such benefits, or the eligibility of Members or Providers to participate in the Medi-Cal managed care program.

B. DHCS has sole authority to establish or interpret policy and its application related to administration of the Medi-Cal program.

C. Contractor must not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits; or eligibility of Members or Providers to participate in the program, without the express, written direction or approval of the DHCS Contracting Officer.

1.1.9 Fulfillment of Obligations

Contractor must not waive any covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract except by written agreement of the parties. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

1.1.10 Obtaining DHCS Approval

A. DHCS Approval of Deliverables Prior to Commencement of Operations

Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and* Requirements) of this Contract, DHCS reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process
Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval; or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c). Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy and completeness of Contractor's certification.

1) Contractor's data submissions must be in a form and manner specified by DHCS:

   a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

   b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services
Managed Care Operations Division

Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority, A Public Agency
dba: CalOptima Health
Attn: Contractor Representative
505 City Parkway West
Orange, CA 92868

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, 2024, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19, (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

Orange County/ies

Unless otherwise specified in this Contract, all Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and remain in effect for others with each Service Area having its own Operations and Phaseout Periods.

1.1.15 Contract Extension

DHCS has the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. Contractor will be given at least nine months prior written notice of DHCS' decision on whether it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the Contract extension within five Working Days of the receipt of the notice from DHCS.

1.1.16 Termination

A.DHCS-Initiated Terminations

1) Mandatory Termination

a) DHCS must terminate this Contract in the event of any of the following:

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Subsection 1.16.A.1 (*Mandatory Termination*) will be effective immediately. Termination under this Section 1.16.A does not relieve Contractor of its obligations under Exhibit E, Section 1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor

under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

B. Contractor-Initiated Terminations

Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any

other information requested by DHCS to evaluate Contractor's financial analysis;

b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Subsection 1.16.B, if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be December 31 of the year in which Contractor gives notice, unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor’s obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor’s Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by

DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Contractor will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, Contractor must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Contractor will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any Subcontractor, Downstream Subcontractor, or Network Provider, necessary to provide effected Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract includes processing, payment, and monetary and data reconciliations necessary regarding Provider claims for Covered Services.

1) Phaseout for this Contract includes the completion of all financial and reporting obligations of Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of this Contract. Contractor must timely submit to DHCS all reports required in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) for the period from the last submitted report through the expiration or termination date, and Contractor will be obligated to cooperate with DHCS with regard to the reconciliation of Contractor's Encounter Data Reporting and Network Provider Data Reporting for up to two years following the expiration or termination of this Contract.

2) All data and information provided by Contractor will be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials provided.

D. The Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable obligations and services.

1.1.18 Indemnification

A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor's next Capitation Payment or any other method to recoup DHCS' costs from Contractor.

1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 23-012, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted

Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member's care, disruption in Contractor's Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 23-012.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; IMR decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers; and Contractor's self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 23-012, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*)*,* is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative

Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;

5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

7) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an alternate dispute officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor’s notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

3) If DHCS’ Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor’s future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor’s appeals will be governed by H&S section 100171, except Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

2) All of Contractor’s appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor’s appeal will be deemed filed on the date it is received by OAHA. Contractor’s appeal must specifically set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor’s failure to provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor’s Dispute Resolution Requirements*). Additionally, Contractor’s appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

a) DHCS acted improperly such that it breached this Contract; and

b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to Contractor arising out of the notice of dispute.

G. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional

substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services (U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

In addition, and in accordance with 42 CFR section 438.3(u), Contractor must retain the following information for no less than ten years and allow auditing entities to inspect and audit:

a) Member Grievance and Appeal records as required in 42 CFR section 438.416;

b) Base data as defined in 42 CFR section 438.5(c);

c) MLR reports as required in 42 CFR section 438.8(k); and

d) Data, information, and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610.

2) Records Retention Period

Notwithstanding any other records retention time period set forth in this Contract, Contractor must maintain all records and documents described in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) for a minimum of ten years from the final date of the Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

B. Right to Audit and Inspect Records and Facilities

1) Authorized Agencies

Contractor agrees that the following agencies, including but not limited to, DHCS, the Centers for Medicare & Medicaid Services (CMS), U.S. DHHS, U.S. DHHS Office of the Inspector General, the Comptroller General of the United States, US DOJ, DMFEA, DMHC, the External Quality Review Organization (EQRO) contractor, and all other agencies authorized under State and federal law (authorized agencies), and their duly authorized representatives or designees, will have the right to audit and inspect the records, documents, and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers.

2) Right to Audit and Inspect at Any Time

DHCS, and its designees, and other authorized agencies and their designees, may, at any time, inspect and audit any and all records, documents, contracts, computers, or other electronic systems maintained by Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, and may, at any time, inspect the premises, facilities, and equipment pertaining directly or indirectly to the delivery of Medi-Cal services pursuant to 42 CFR sections 438.3(h) and (u) and 438.230(c), and other applicable State and federal law.

3) Scope of Inspection

DHCS and other authorized agencies may, at any time, audit, inspect, and monitor, Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, to assure compliance with any provision of this Contract; evaluate the quality, appropriateness, and timeliness of services performed under this Contract; and for any other reasonable purpose.

Upon request, and through the end of the records retention period specified in Exhibit E, Subsection 1.1.22.A.2 (*Inspection and Audit of Records and Facilities*), Contractor must furnish any record, or copy of it, to DHCS or any other auditing entity listed in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), at Contractor's sole expense.

4) Right to Audit and Inspect Exists for Ten Years

The right to audit and inspect under this this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) exists for ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

5) Additional Facility Inspection Rights

In addition to Exhibit D(f), Section 8 (*Site Inspection*) in order to ensure compliance with this Contract, and for any other reasonable purpose, Contractor agrees to the following:

a) DHCS, and its authorized representatives and designees, and authorized agencies, and their authorized representatives and designees, will have the right to access the premises and facilities of Contractor, and the premises and facilities of its Subcontractors, Downstream Subcontractors, and Network Providers, with or without notice, including, but not limited to, the management information systems operations site or such other places where duties and obligations under the Contract are performed.

b) Staff designated by DHCS, and the designated staff of other authorized agencies, must be provided access to security areas of all Contractor, and its Subcontractors, Downstream Subcontractors,' and Network Providers, . Contractor must

provide, and must require any and all of its Subcontractors, Downstream Subcontractors, and Network Providers to provide, reasonable cooperation and assistance to auditing representatives in the performance of their duties.

c) DHCS may conduct unannounced inspections and audits of the premises and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, selected at DHCS' sole discretion, to verify compliance of these sites with DHCS requirements.

1.23 Confidentiality of Information

In addition to Exhibit D(f), Section 14 (*Confidentiality of Information*), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members will be protected by Contractor.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report to DHCS requests for Medical Records made in accordance with applicable law, unless the law requires such reporting.

B. With respect to any identifiable information obtained by Contractor, or its Subcontractors, Downstream Subcontractors, or Network Providers, concerning a Member under this Contract, Contractor will ensure the following:

1) Any such information will not be used for any purpose other than carrying out the express terms of this Contract;

2) All requests for disclosure of such information will be promptly transmitted to DHCS, except requests for Medical Records in accordance with applicable law;

3) Any such information will not be disclosed, except as otherwise specifically permitted by this Contract, to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder; and

4) At the termination of this Contract, the return all such information to DHCS or maintain such information as directed by DHCS.

C. Contractor will have provisions in its Subcontractor Agreements and Network Provider Agreements requiring Subcontractors, Downstream Subcontractors, and Network Providers to comply with this Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*).

1.1.24 Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor's obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor's Service Area will be implemented through a contract amendment.

1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage

A. Contractor must Cost Avoid or make a Post-Payment Recovery (PPR) for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's Other Health Coverage (OHC) covers the same services, fully or partially. However, in no event may Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor must, at a minimum, utilize the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

C. Contractor retains all monies for PPR when Contractor initiates and completes recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

D. If Contractor initiates an active repayment plan with Network Providers or third-party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.

E. Contractor must coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.

F. If Contractor does not perform PPR for a Member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such activity.

G. Cost Avoidance

1) Contractor must not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third-party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply 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 demonstrating that Provider has billed the OHC and received no response for at least 90 calendar days.

2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party

coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs . Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers , relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2). State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a "person most knowledgeable," and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. Comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans

with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; treating a Member or Potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not terminate the Enrollment of a Member based on an adverse change in the Member's health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in

Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be in a form satisfactory to DHCS, and provide for the full and prompt performance of all covenants, terms and conditions, and agreements throughout the term of the Contract.

1.1.34 Priority of Provisions

In the event of a conflict between the provisions of Exhibit D(f) (*Special Terms and Conditions*) and any other Exhibits of this Contract, the provisions in the other Exhibits will prevail over the provisions in Exhibit D(f). Additionally, where Exhibit D(f) contains provisions on the same subject matter as a provision in another Exhibit of this Contract, the language in the other Exhibit preempt and prevail over the language in Exhibit D(f).

In the event of a conflict between any Article summary (Articles 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0) and a more specific term in this Contract, the more specific term will prevail over the Article summary.

1.1.35 Additional Incorporated Provisions – Proposals

Any and all final Proposals, including Exhibits and Attachments (collectively referred to as "Proposal"), submitted by Contractor in response to the Request for Proposal 20-10029 (RFP), or any subsequent Requests for Proposal in connection with any managed care contract, are hereby incorporated by reference into this Contract. DHCS is relying on Contractor's representations in Contractor's Proposal in awarding contracts, and, accordingly, DHCS may enforce such representations against Contractor, including, but not limited to, representations that it will perform in a certain manner, provide enhanced services, and/or meet more stringent requirements than those required in the Contract. Contractor is required to obtain written approval from DHCS before implementing any such enhanced services or requirements reflected in Contractor's Proposal. In the event the Proposal(s) does not address Contract requirements, the Contract will govern.

1.1.36 Miscellaneous Provisions

A. Antitrust Claims

By signing this Contract, Contractor hereby certifies that if these services or goods are obtained by means of a competitive bid, Contractor must comply with the Antitrust Claims requirements of the GC sections 4550 *et seq.*.

B. Child Support Compliance Act

Contractor recognizes the importance of Child and family support obligations and must fully comply with all applicable State and federal laws relating to Child and family support enforcement (Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code).

C. Priority Hiring Considerations

Contractor must give priority consideration in filling vacancies in positions funded by the Contract to qualified recipients of aid under W&I section 11200 in accordance with PC section 10353.

D. Interoperability

1) Contractor must comply with the CMS Interoperability and Patient Access Final Rule, as set forth in 42 CFR sections 406, 407, 422, 423, 431, 438, 457, 482 and 485, and 45 CFR section 156.

2) Contractor must ensure that its contracted hospitals comply with the electronic notification requirements as set forth in 42 CFR section 482.24(d).

3) Contractor must participate in the California Health and Human Services Data Exchange Framework to exchange health information or provide access to health information to and from various entities in real time as set forth in H&S section 130290.

E Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

1) Contractor must collaborate with DHCS, and take action as required by DHCS, to comply with and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers comply with federal requirements for Electronic Visit Verification (EVV) set forth in 42 USC section 1396b(l) and with State requirements for EVV set forth in W&I section 14043.51, Section 12006(a) of the Federal Cures Act, and APL 22-014.

2) Contractor must implement and ensure that its applicable Subcontractors, Downstream Subcontractors, and Network Providers implement a State-approved EVV solution, as required, for personal care services and home health care services provided in a Member's home.

3) Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing Personal Care Services and Home Health Care Services in a Member's home:

   a) The type of service performed;

   b) The individual receiving the service;

   c) The date of the service;

   d) The location of service delivery;

   e) The individual providing the service; and

   f) The time the service begins and ends.

4) Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

   a) Monitor providers for compliance with the EVV requirements and Information Notice(s), and alert DHCS to any compliance issues.

   b) Supply Providers with technical assistance and training on EVV compliance.

   c) Require Providers to comply with an approved corrective action plan.

   d) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

1.1.37 Data Sharing

A. General Statement

Contractor must transfer all data in compliance with the terms of this Contract, including but not limited to the requirements of Exhibit G (*Business Associate Addendum*). Nothing in this Contract is exhaustive, exclusive, or limiting of DHCS' ability to provide data to Contractor or receive data from Contractor should DHCS determine, in its sole discretion, that the data is necessary and appropriate for Contractor to perform its duties under this Contract.

B. Post-Termination/Expiration Transactions; Survival of Terms

When this Contract terminates or expires, Contractor must continue to exchange data in order to facilitate an orderly phaseout of Contract requirements including, but not limited to, data sharing in connection with continuity of care for Members, Encounter Data reconciliation, Network Provider Data Reporting, and payment reconciliation. These phaseout transactions will require the transfer of data between Contractor and DHCS, including Protected Health Information (PHI) and other potentially sensitive data. To facilitate the safe and secure transfer of data, all requirements of this Contract pertaining to the transfer of data, including but not limited to Exhibit G (*Business Associate Addendum)*, will survive the termination or expiration of this Contract for as long as any PHI or other sensitive data remains in the possession of Contractor. This Subsection is intended to supplement and not replace the requirements of Exhibit G (*Business Associate Addendum*) regarding data sharing.

Exhibit F – Contractor's Release

Contractor's Release

Instructions to Contractor:

With final invoice(s), submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** ___entered into between the Department of Health Care Services (DHCS) and Contractor (identified below), Contractor does acknowledge that final payment has been requested via **invoice number(s)** ___, in the **amount(s) of $** and **dated** ___. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement do not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of postconsumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Public Contract Code Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract):
Signature of Contractor or Official Designee:
Date:

Printed Name/Title of Person Signing:
Distribution: Accounting (Original)   Program

Exhibit G – Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by federal and/or State laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which State and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS’ behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI,

inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other State and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable State or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, W&I section 5328, and Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5 is available online; updates will be available online at the NIST Computer Security Resource Centerhttps://csrc.nist.gov/publications/sp800.

9.2.3 Business Associate employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online at the NIST Cryptographic Module Validation Program page, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online. In addition, Business Associate maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement be renewed annually.

9.2.6 Business Associate identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR part 164, subpart C.

9.3 Business Associate's Agent. Business Associate ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. Mitigation of Harmful Effects. Business Associate mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. Access to PHI. Business Associate make PHI available in accordance with 45 CFR section 164.524.

12. Amendment of PHI. Business Associate make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. Accounting for Disclosures. Business Associate make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. Compliance with DHCS Obligations. To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR part 164, subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. Access to Practices, Books and Records. Business Associate make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR part 164, subpart E.

16. Return or Destroy PHI on Termination; Survival. At termination of this Agreement, if feasible, Business Associate return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business

Associate determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate provide notice by telephone to DHCS.

18.1.2 Business Associate notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and include all information known at the time the incident is reported. The Privacy Incident Reporting Form is available online.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable federal and State law.

18.2 Investigation. Business Associate immediately investigate such security incident or breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" include any applicable additional information not included in the Initial Form. The Final PIR Form include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and State laws. The report also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate notify individuals accordingly and pay all costs of such notifications,

as well as all costs associated with the breach. The notifications comply with applicable federal and State law. DHCS approve the time, manner and content of any such notifications and their review and approval be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and State law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or State law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate promptly remedy any violation of this Agreement and certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be

binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H – Conflict of Interest Avoidance Requirements

1.0 The Department of Health Care Services (DHCS) requires Contractor to avoid conflicts of interest or the appearance of conflicts of interest. DHCS reserves the right to determine, in DHCS' sole discretion, whether any information received from any source indicates the existence of a potential, suspected, and/or actual conflict of interest.

Exhibit H

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction
1.1.2 Identification of Ownership, Contractual, and Financial Interests
1.1.3 Conflicts of Interest
1.1.4 DHCS Approval of Conflict Avoidance Plan
1.1.5 Third-Party Monitor Oversight
1.1.6 DHCS' Right of Termination
1.1.7 Notice of Conflict of Interest to DHCS

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction

Contractor must ensure that it complies with the conflict of intererst avoidance requirements set forth in this Exhibit H and must also ensure the compliance of its employees, officers, and directors throughout the entire term of the Contract, and any extensions thereto. Contractor must also ensure that its Subcontractors and Downstream Subcontractors (as those terms are defined in the Contract), and the employees, officers and directors of Subcontractors and Downstream Subcontractors, comply with the requirements set forth in this Exhibit H throughout the entire term of the Contract, and any extension thereto.

1.1.2 Identification of Ownership, Contractual, and Financial Interests

Contractor will disclose the following to DHCS, in a form and manner directed by DHCS through All Plan Letter (APL) or other similar instructions:

A. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation or other entity that operates as a Medi-Cal managed care health plan, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), pharmaceutical company or any other health care provider, fiscal intermediary, billing agent, or any other controlling agent for Medi-Cal services (“Medi-Cal Program Participant”); and

B. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation, partnership, limited partnership, limited liability company, sole proprietorship, or any other legal entity that is not a Medi-Cal Program Participant.

To the extent any interest identified by Contractor in Section 1.2 results in a potential, suspected, and/or actual conflict of interest, Contractor will be subject to all requirements of this Exhibit H.

1.1.3 Conflicts of Interest

If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor must provide a description of the relationship and a conflict avoidance plan to ensure that such a relationship will not adversely affect DHCS, other Medi-Cal managed care plans, and/or Medi-Cal Members. In the conflict

avoidance plan, Contractor must also establish procedures to avoid, neutralize, and/or mitigate a potential, suspected, and/or actual conflict of interest.

Any of the following instances would be considered a potential, suspected, and/or actual conflict of interest, including but not limited to any of these instances in the past, present, or future:

A. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is inconsistent with the goals and objectives of the Contract;

B. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, improperly uses their positions for purposes that are, or give the appearance of being, for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by DHCS to be a conflict of interest;

C. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, gains an unfair competitive advantage due to its unequal access to information, such as where non-public information gained on one contract by Contractor may be leveraged in bidding for another government contract;

1) Where pursuant to the Political Reform Act (Govt. Code (GC) §§ 87100–87500), a DHCS official has an economic Interest in Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor where it is reasonably foreseeable that the decision could materially affect the official's economic interest;

2) Where pursuant to GC section 1090 *et seq*., a DHCS official participates in the making of a Contract with Contractor and the official is financially interested in the Contract;

3) Where in contravention of Welfare and Institutions Code (W&I) section 14479, a DHCS officer or employee is employed in a management or consultant position by Contractor, Subcontractor, or Downstream Subcontractor one year after the DHCS officer or employee terminates their State employment; and

4) For Two-Plan managed care models, an instance where Contractor will be contracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the same Two-Plan county where Contractor is operarting as the commercial plan, or has indicated an intent to do so.

D. Conflict Avoidance Plan Framework

The requirements of a conflict avoidance plan will vary depending on the nature of the conflict, but must include, at a minimum, the following elements:

1) Clear definitions;

2) Statement of organizational commitment to develop and follow the conflict avoidance plan;

3) Description of the type of conflict of interest (*e.g.*, unequal access to information, impaired objectivity, and/or biased ground rules implicated by a contract);

4) Description of the factors that may or do place Contractor in a potential, suspected, and/or actual conflict of interest situation;

5) If applicable, identification of Subcontractors and Downstream Subcontractors with potential, suspected, and/or actual conflict of interest;

6) Detailed plans for avoiding, neutralizing, and/or mitigating conflicts of interest, or, if not feasible, an explanation and justification for accepting conflicts of interest;

7) Administrative, technical, physical, and management controls, as required in the context of the specific conflict of interest;

8) Provision for third-party monitoring and a requirement that the third-party monitor certify Contractor's compliance with the conflict avoidance plan, if required by DHCS;

9) Contractor’s certification of compliance with the conflict avoidance plan; and

10) Provisions requiring periodic review and amendment by Contractor of the conflict avoidance plan to address material changes impacting the conflict of interest.

1.1.4 DHCS Approval of Conflict Avoidance Plan

DHCS, in its sole discretion, will determine whether the specific provisions of the conflict avoidance plan satisfactorily address the actual, suspected, or potential conflicts of interest. DHCS, in its sole discretion, may impose additional requirements or require modification to the conflict avoidance plan, which may include, but are not limited to, the following:

A. Termination of contractual obligations that in DHCS’ determination create actual or potential conflicts of interest;

B. Removal of Contractor’s management or staff who DHCS determines were involved in the relationship creating the conflict of interest; and/or

C. Creation of an “ethical firewall,” with measures to ensure that no information passes between individuals/entities within Contractor’s organization that were involved in the conflict and those individuals/entities not involved in the conflict.

These requirements will vary, depending on the nature of the potential, suspected, and/or actual conflicts of interest, the manner in which those potential, suspected, and/or actual conflicts of interest impact the Contract, and DHCS’ determination of the best method for addressing those conflicts of interest.

1.1.5 Third-Party Monitor Oversight

DHCS may, in its sole discretion, appoint a third-party monitor to assist in overseeing Contractor’s compliance with the conflict avoidance plan. The third-party monitor’s responsibilities will include monitoring, reporting, consulting, and, where necessary, investigation of compliance concerns. Appropriate provisions regarding the third-party monitor’s duties and Contractor’s obligations in connection with the third-party monitor will be included in the conflict avoidance plan.

1.1.6 DHCS' Right of Termination

If DHCS is aware or becomes aware of a potential, suspected, and/or actual conflict of interest, Contractor will be given an opportunity to submit additional information to resolve the conflict of interest. If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor will have five Working Days from the date of notification by DHCS of the potential, suspected, and/or actual conflict of interest to provide complete information regarding the conflict of interest. If DHCS determines that an actual conflict of interest exists and the conflict cannot be resolved or mitigated to the satisfaction of DHCS, the conflict of interest will be grounds for termination of the Contract by DHCS for cause.

1.1.7 Notice of Conflict of Interest to DHCS

Contractor, and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten Working Days of when they become aware of any potential, suspected, or actual conflict of interest, or when any change occurs to the information provided to DHCS previously, whether provided previously through the Request for Procurement or previous notice given during the term of the Contract. This notice will be in a form and manner as directed by DHCS through APL or other similar instructions.

Exhibit I – Contractor's Parent Guaranty Requirements

1.0 Contractor's Parent Guaranty Requirements

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract (the "Guarantor").

1.1 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements
1.1.2 Provisions
1.1.3 Terms

1.0 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements

The Guaranty must, at a minimum, meet the following requirements. It must:

A. Be made to DHCS, in writing, by the Contract effective date;

B. Be signed by an official authorized to bind the Guarantor organization;

C. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity (TNE) and payment of liquidated damages;

D. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;

E. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;

F. State that the undersigned corporate officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and

G. State that the undersigned corporate officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into this Guaranty

1.1.2 Provisions

The Guaranty must include the following provisions:

A. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;

B. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee;

C. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

D. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

1.1.3 Terms

The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor’s financial responsibility.

Exhibit J: Delegation Reporting and Compliance Plan

This Exhibit contains instructions and templates for Contractor to make submissions to DHCS per the requirements set forth in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan)*. As with all Exhibits to the Contract, Exhibit J is a part of this Contract and the reporting requirements in this Exhibit J and the use of the prescribed template are binding and enforceable contractual obligations under this Contract. Contractor must complete Exhibit J for each county in which they operate.

Template A: Delegation Function Matrix

Instructions: Complete *Table A1: Delegation Function Matrix – For Subcontractor* for all functions that are delegated through applicable Subcontractor Agreements. Contractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Use additional pages of Table A1 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Contractor Name:

Applicable County:

Compliance Officer:

Compliance Contact Information:

1. **Subcontractor Name:** Name of the Subcontractor with whom Contractor has a Subcontractor Agreement

2. **Type of Subcontractor:** Fully Delegated Subcontractor, Partially Delegated Subcontractor, Administrative Subcontractor

3. **Delegated Function(s):** The function(s) Contractor is delegating to Subcontractor. In the case of a Fully Delegated Subcontractor, this may be “all delegable functions.”

4. **Address:** The address for location of the performance of Subcontractor’s functions

5. **Contact Info:** Name and contact information for each of Subcontractor’s key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Subcontractor if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Subcontractor is at risk, if applicable.

Table A1: Delegation Function Matrix—For Subcontractors

Sub-contractor Name (1)	Type of Sub-contractor (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Instructions: Complete *Table A2 Delegation Function Matrix—Downstream Subcontractors* for all functions that are delegated through applicable Downstream Subcontractor Agreements. Use additional pages of Table A2 as needed. Subcontractor or Downstream Subcontractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Complete one for each Subcontractor that delegates functions downstream and, as applicable, for each Downstream Subcontractor, if they further delegate functions downstream. Use additional pages of Table A2 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Subcontractor or Downstream Subcontractors Name:
Applicable County(ies):
Compliance Officer:
Compliance Contact Information:

1. **Downstream Subcontractor Name:** Name of the Downstream Subcontractor with whom the Subcontractor has a Downstream Subcontractor Agreement; or the name of the Downstream Subcontractor with whom the Subcontractor's Downstream Subcontractor further delegates functions downstream
2. **Type of Downstream Subcontractor:** Downstream Fully Delegated Subcontractor, Downstream Partially Delegated Subcontractor, Downstream Administrative Subcontractor
3. **Delegated Function(s):** The function(s) Subcontractor is delegating to Downstream Subcontractor; in the case of a Downstream Fully Delegated Subcontractor, this may be "all delegable functions."
4. **Address:** The address of the location of the performance of the Downstream Subcontractor's functions.
5. **Contact Info:** Name and contact information for each of the Downstream Subcontractor's key personnel who is responsible for ensuring compliance.
6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Downstream Subcontractor, if applicable.
7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Downstream Subcontractor, is at risk, if applicable.

Table A2: Delegation Function Matrix—For Downstream Subcontractors

Downstream Subcontractor Name (1)	Type (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Template B: Delegation Justification and Plan

Instructions: Complete this template for each Subcontractor or Downstream Subcontractor. Contractor may not delegate for those contractual duties and obligations where delegation is legally or contractually prohibited. Responses must be limited to no more than ten pages.

Subcontractor or Downstream Subcontractor Name:

Applicable County(ies):

Subcontractor or Downstream Key Personnel:

Subcontractor Key Personnel Contact Information:

Type of Subcontractor or Downstream Subcontractor: Fully delegated, Partially delegated, Administrative, Downstream Fully delegated, Downstream Partially delegated, Downstream Administrative:

a) **Justification of Subcontractor Agreement or Downstream Subcontractor Agreement:** Describe the purpose and the justification of the Subcontractor Agreement or Downstream Subcontractor Agreement.

b) **Pre-Existing Relationships:** Describe any pre-existing relationship, including any affiliation, parent entity, or prior existing contract between Contractor and Subcontractor, or Subcontractor and Downstream Subcontractor including the duration of such pre-existing relationship.

c) **Sub-Delegation**: Indicate if Subcontractor or Downstream Subcontractor is permitted to sub-delegate any functions. If so, describe how Contractor will maintain oversight over delegated functions to Subcontractors and Downstream Subcontractors. Provide citations to provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement to support Contractor's assertions.

d) **Impact on Contractor:** Describe the impact and benefit, if any, the Subcontractor Agreement or Downstream Subcontractor Agreement will have on Contractor's operations, administrative capacity, and financial viability.

e) **Contractor's Administrative Capacity to Oversee and Monitor Subcontractor and Downstream Subcontractor:** Describe Contractor's administrative capacity to oversee and monitor Subcontractor and Downstream Subcontractor as applicable

f) **Subcontractor's and Downstream Subcontractor's Administrative Capacity:** Describe Subcontractor's and Downstream Subcontractor's administrative capacity to perform each delegated function, including but not limited to Subcontractor's and Downstream Subcontractor's capacity to perform quality monitoring and community engagement, if applicable.

g) **Subcontractor's and Downstream Subcontractors' Compliance with Applicable Contractual Provisions:** Detail how the Subcontractor Agreement and Downstream Subcontractor Agreement complies with, and ensures compliance, with all provisions of the Contract applicable to the delegated functions, including appropriate citations to the provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement. Please complete Template C (Contract Requirements Grid) in Exhibit J to indicate which provisions are included in the Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable for each Agreement.

h) **Contractor's Oversight Policy and Procedures:** Describe how Contractor will inform Subcontractor and Downstream Subcontractors of Contractor's oversight policies and procedures.

i) **Financial Arrangement:** Contractor must include description of any financial arrangements it has with Subcontractor and Downstream Subcontractor.

j) **Other Information:** Include any other information that would assist DHCS in its review of Contractor's delegated structure.

k) **Previously Approved Documents: (Applicable to annual submissions only)** If Contractor has previously submitted documentation to DHCS in connection with the Subcontractor Agreement or Downstream Subcontractor Agreement, either through the Request for Proposal (RFP) process or during the term of this Contract, Contractor must provide any such documentation.

Template C: Contract Requirements Grid

Instructions: If you delegate any functions, complete this template for those contractual duties. One Template C should be submitted showing all delegated functions to accompany Templates A and B.

Contractors must complete this table to indicate all the contract requirements that are applicable to their Subcontractors or Downstream Subcontractor, depending on the functions that are delegated to the respective entities.

This table also references obligations of Contractor where delegation must be contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is contractually prohibited, Contractor or Subcontractor or Downstream Subcontractor may include related contractual requirements in their Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs. Regardless of Contractor's system of delegation, Contractor remains obligated to ensure performance of all duties and obligations under the Contract.

Fully Delegated Subcontractors must comply with all contractual requirements. Partially Delegated Subcontractors and Downstream Partially Delegated Subcontractors, and Administrative Subcontractors and Downstream Administrative Subcontractors must at minimum comply with requirements outlined in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*.

Additional requirements may apply depending on the nature of the function or functions delegated. For example, if a Subcontractor delegates claims processing to an Administrative Downstream Subcontractor for this function, the Administrative Downstream Subcontractor must comply with Exhibit A, Attachment III, Subsection 3.3.5 *(Claims Processing)* for all requirements related to timely processing of claims.

Delegating functions or including contractual provisions in Subcontractor Agreements or Downstream Subcontractor Agreements does not absolve Contractor of ensuring compliance of the Subcontractors or Downstream Subcontractors.

Note:

(1) Must not be delegated: These rows reference contractual requirements associated with functions for which delegation is contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is legally or contractually prohibited, Contractor may include related contractual requirements in the Subcontractor Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs.

Contractor Name:

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.0 Organization	
1.1 Plan Organization and Administration	
1.1.1 Legal Capacity	☐
1.1.2 Key Personnel Disclosure Form	☐
1.1.3 Conflict of Interest – Current and Former State Employees	☐
1.1.4 Contract Performance	☐
1.1.5 Medical Decisions	☐
1.1.6 Medical Director	☐
1.1.7 Chief Health Equity Officer	*(1) Must not be delegated*
1.1.8 Key Personnel Changes	☐
1.1.9 Administrative Duties/Responsibilities	☐
1.1.10 Member Representation	☐
1.1.11 Diversity, Equity, and Inclusion Training	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
1.2	**Financial Information**	
1.2.1	Financial Viability and Standards Compliance	☐
1.2.2	Contractor's Financial Reporting Obligations	☐
1.2.3	Independent Financial Audit Reports	☐
1.2.4	Cooperation with DHCS' Financial Audits	☐
1.2.5	Medical Loss Ratio	*(1) Must not be delegated*
1.2.6	Contractor's Obligations	☐
1.2.7	Community Reinvestment Plan and Report	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
1.3	**Program Integrity and Compliance Program**	
1.3.1	Compliance Program	*(1) Must not be delegated*
1.3.2	Fraud Prevention Program	☐
1.3.3	Provider Screening, Enrolling, and Credentialing/Recredentialing	☐
1.3.4	Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers	☐
1.3.5	Disclosures	☐
1.3.6	Treatment of Overpayment Recoveries	☐
1.3.7	Federal False Claims Act Compliance and Support	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.0 Systems and Processes	
2.1 Management Information System	
2.1.1 Management Information System Capability	☐
2.1.2 Encounter Data Reporting	☐
2.1.3 Participation in the State Drug Rebate Program	☐
2.1.4 Network Provider Data Reporting	☐
2.1.5 Program Data Reporting	☐
2.1.6 Template Data Reporting	☐
2.1.7 Management Information System/Data Audits	☐
2.1.8 Management Information System/Data Correspondence	☐
2.1.9. Tracking and Submitting Alternative Format Selections	☐
2.1.10 Interoperability Application Programming Information System Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.2 Quality Improvement and Health Equity Transformation Program	
2.2.1 Quality Improvement and Health Equity Transformation Program Overview	☐
2.2.2 Governing Board	☐
2.2.3 Quality Improvement and Health Equity Committee	☐
2.2.4 Provider Participation	☐
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities	☐
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures	☐
2.2.7 Quality Improvement and Health Equity Annual Plan	☐
2.2.8 National Committee for Quality Assurance Accreditation	*(1) Must not be delegated*
2.2.9 External Quality Review Requirements	☐
2.2.10 Quality Care for Children	☐
2.2.11 ~~Quality Monitoring for~~ Skilled Nursing Facilities—Long-Term Care	☐
2.2.12 Disease Surveillance	☐
2.2.13 Credentialing and Recredentialing	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.3 Utilization Management Program	
2.3.1 Prior Authorizations and Review Procedures	☐
2.3.2 Timeframes for Medical Authorization	☐
2.3.3 Review of Utilization Data	☐
2.3.4 Delegating Utilization Management Activities	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.0 Provider, Network Providers, Subcontractors, and Downstream Subcontractors	
3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties	
3.1.1 Overview of Contractor's Duties and Obligations	☐
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan	☐
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance	*(1) Must not be delegated*
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers	☐
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics	☐
3.1.8 Network Provider Agreements with Safety-Net Providers	☐
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments	☐
3.1.10 Nondiscrimination in Provider Contracts	☐
3.1.11 Public Records	☐
3.1.12 Requirement to Post	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.2 Provider Relations	
3.2.1 Exclusivity	☐
3.2.2 Provider Dispute Resolution Mechanism	☐
3.2.3 Out-of-Network Provider Relations	☐
3.2.4 Contractor's Provider Manual	☐
3.2.5 Network Provider Training	☐
3.2.6 Emergency Department Protocols	☐
3.2.7 Prohibited Punitive Action Against the Provider	☐
3.2.8 Submittal of Inpatient Days Information	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.3 Provider Compensation Arrangements	
3.3.1 Compensation and Value Based Arrangements	☐
3.3.2 Capitation Arrangements	☐
3.3.3 Provider Financial Incentive Program Payments	☐
3.3.4 Identification of Responsible Payor	☐
3.3.5 Claims Processing	☐
3.3.6 Prohibited Claims	☐
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider	☐
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers	☐
3.3.9 Non-Contracting Family Planning Providers	☐
3.3.10 Sexually Transmitted Disease	☐
3.3.11 Human Immunodeficiency Virus Testing and Counseling	☐
3.3.12 Immunizations	☐
3.3.13 Community Based Adult Services	☐
3.3.14 Organ and Bone Marrow Transplants	☐
3.3.15 Long-Term Care Services	☐
3.3.16 Emergency Services and Post-Stabilization Care Services	☐
3.3.17 Provider-Preventable Conditions	☐
3.3.18 Prohibition Against Payment to Excluded Providers	☐
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
4.0	**Member**	
4.1	**Marketing**	
4.1.1	Training and Certification of Marketing Representatives	☐
4.1.2	Marketing Plan	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
4.2	**Enrollments and Disenrollments**	
4.2.1	Enrollment	☐
4.2.2	Disenrollment	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.3 Population Health Management and Coordination of Care	
4.3.1 Population Health Management Program Requirements	☐
4.3.2 Population Needs Assessment	☐
4.3.3 Data Integration and Exchange	☐
4.3.4 Population Health Management Service	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐

Contractual Requirements	Delegated to Subcontractor
4.3.23 Justice Involved Reentry Coordination	☐
~~4.3.23~~**4.3.24** Managed Care Liaisons	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.4 Enhanced Care Management	
4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management	☐
4.4.2 Populations of Focus for Enhanced Care Management	☐
4.4.3 Enhanced Care Management Providers	☐
4.4.4 Enhanced Care Management Provider Capacity	☐
4.4.5 Enhanced Care Management Model of Care	☐
4.4.6 Member Identification for Enhanced Care Management	☐
4.4.7 Authorizing Members for Enhanced Care Management	☐
4.4.8 Assignment to an Enhanced Care Management Provider	☐
4.4.9 Initiating Delivery of Enhanced Care Management	☐
4.4.10 Discontinuation of Enhanced Care Management	☐
4.4.11 Core Service Components of Enhanced Care Management	☐
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management	☐
4.4.13 Oversight of Enhanced Care Management Providers	☐
4.4.14 Payment of Enhanced Care Management Providers	☐
4.4.15 Enhanced Care Management Reporting Requirements	☐
4.4.16 Enhanced Care Management Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.5 Community Supports	
4.5.1 Contractor's Responsibility for Administration of Community Supports	☐
4.5.2 DHCS Pre-Approved Community Supports	☐
4.5.3 Community Supports Providers	☐
4.5.4 Community Supports Provider Capacity	☐
4.5.5 Community Supports Model of Care	☐
4.5.6 Identifying Members for Community Supports	☐
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status	☐
4.5.8 Referring Members to Community Supports Providers for Community Supports	☐
4.5.9 Data System Requirements and Data Sharing to Support Community Supports	☐
4.5.10 Contractor's Oversight of Community Supports Providers	☐
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors	☐
4.5.12 Payment of Community Supports Providers	☐
4.5.13 Community Supports Reporting Requirements	☐
4.5.14 Community Supports Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.6 Member Grievance and Appeal System	
4.6.1 Grievance and Appeal Program Requirements	☐
4.6.2 Grievance Process	☐
4.6.3 Discrimination Grievances	☐
4.6.4 Notice of Action	☐
4.6.5 Appeal Process	☐
4.6.6 Responsibilities in Expedited Appeals	☐
4.6.7 State Hearings and Independent Medical Reviews	☐
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted	☐
4.6.9 Grievance and Appeal Reporting and Data	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.0 Services – Scope and Delivery	
5.1 Member Services	
5.1.1 Members Rights and Responsibilities	☐
5.1.2 Member Services Staff	☐
5.1.3 Member Information	☐
5.1.4 Primary Care Provider Selection	☐
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.2 Network and Access to Care	
5.2.1 Access to Network Providers and Covered Services	☐
5.2.2 Network Capacity	☐
5.2.3 Network Composition	☐
5.2.4 Network Ratios	☐
5.2.5 Network Adequacy Standards	☐
5.2.6 Access to Emergency Service Providers and Emergency Services	☐
5.2.7 Out-of-Network Access	☐
5.2.8 Specific Requirements for Access to Programs and Covered Services	☐
5.2.9 Network and Access Changes to Covered Services	☐
5.2.10 Access Rights	☐
5.2.11 Cultural and Linguistic Programs and Committees	☐
5.2.12 Continuity of Care for Seniors and Persons with Disabilities	☐
5.2.13 Network Reports	☐
5.2.14 Site Review	☐
5.2.15 Street Medicine	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.3 Scope of Services	
5.3.1 Covered Services	☐
5.3.2 Medically Necessary Services	☐
5.3.3 Initial Health Appointment	☐
5.3.4 Services for Members Less Than 21 Years of Age	☐
5.3.5 Services for Adults	☐
5.3.6 Pregnant and Postpartum Members	☐
5.3.7 Services for All Members	☐
5.3.8 Investigational Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.4 Community Based Adult Services	
5.4.1 Covered Services	☐
5.4.2 Coordination of Care	☐
5.4.3 Required Reports for the Community Based Adult Services Program	☐
5.4.4 Community Participation	☐
5.4.5 Community Based Adult Services Program Integrity	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.5 Mental Health and Substance Use Disorder Benefits	
5.5.1 Mental Health Parity Requirements	☐
5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services	☐
5.5.3 Non-specialty Mental Health Services Providers	☐
5.5.4 Emergency Mental Health and Substance Use Disorder Services	☐
5.5.5 Mental Health and Substance Use Disorder Services Disputes	☐
5.5.6 No Wrong Door for Mental Health Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.6 MOUs with Local Government Agencies, County Programs, and Third Parties	
5.6.1 MOU Purpose	☐
5.6.2 MOU Requirements	☐
5.6.3 MOU Oversight and Compliance	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
6.0 Emergency Preparedness and Response	
6.1 General Guidance	☐
6.2 Business Continuity Emergency Plan	☐
6.3 Member Emergency Preparedness Plan	☐
6.4 California's Standardized Emergency Management System	☐
6.5 Reporting Requirements During an Emergency	☐
6.6 DHCS Emergency Directives	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
7.0 Operations Deliverables and Requirements	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit E		
1.0	**Program Terms and Conditions**	
1.1	Governing Law	☐
1.2	DHCS Guidance	☐
1.3	Contract Interpretation	☐
1.4	Assignments, Mergers, Acquisitions	☐
1.5	Independent Contractor	☐
1.6	Amendment and Change Order Process	☐
1.7	Delegation of Authority	*(1) Must not be delegated*
1.8	Authority of the State	☐
1.9	Fulfillment of Obligations	☐
1.10	Obtaining DHCS Approval	☐
1.11	Certifications	☐
1.12	Notices	☐
1.13	Term	☐
1.14	Service Area	☐
1.15	Contract Extension	☐
1.16	Termination	☐
1.17	Phaseout Requirements	☐
1.18	Indemnification	☐
1.19	Sanctions	☐
1.20	Liquidated Damages	☐
1.21	Contractor’s Dispute Resolution Requirements	☐
1.22	Inspection and Audit of Records and Facilities	☐
1.23	Confidentiality of Information	☐

Contractual Requirements		Delegated to Subcontractor
1.24	Pilot Projects	☐
1.25	Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)	☐
1.26	Third-Party Tort and Workers' Compensation Liability	☐
1.27	Litigation Support	☐
1.28	Equal Opportunity Employer	☐
1.29	Federal and State Nondiscrimination Requirements	☐
1.30	Discrimination Prohibitions	☐
1.31	Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements	☐
1.32	Conflict of Interest Avoidance Requirements	*(1) Must not be delegated*
1.33	Guaranty Provision	☐
1.34	Priority of Provisions	☐
1.35	Additional Incorporated Provisions – Proposals	☐
1.36	Miscellaneous Provisions	☐

Exhibit K – Excluded Provisions as to Contractors Not Licensed Pursuant to the Knox-Keene Health Care Service Plan Act of 1975

Unless otherwise specified in this Contract, the following provisions of the Knox-Keene Health Care Service Plan Act of 1975, (KKA) and its implementing regulations (22 California Code of Regulations (CCR) section 1000, *et seq*.) are excluded from this Contract if Contractor is not licensed to operate as a health care service plans pursuant to the KKA. This list is not exhaustive or exclusive since other provisions of the KKA may also be excluded from the Contract pursuant to Exhibit E, Section 1.1.D (*Applicability of the Knox-Keene Act*) or other provisions of the Contract:

1. Health and Safety Code (H&S) sections 1341 – 1341.14.
2. H&S sections 1342.4 – 1342.73.
3. H&S sections 1346 – 1347.5.
4. H&S sections 1348.9 – 1348.96.
5. H&S, Article 3 of Chapter 2.2 of Division 2.
6. H&S, Article 3.1 of Chapter 2.2 of Division 2.
7. H&S, Article 3.15 of Chapter 2.2 of Division 2.
8. H&S, Article 3.16 of Chapter 2.2 of Division 2.
9. H&S, Article 3.17 of Chapter 2.2 of Division 2.
10. H&S, Article 3.5 of Chapter 2.2 of Division 2.
11. H&S sections 1359 – 1361.1.
12. H&S section 1363.01.
13. H&S section 1363.03.
14. H&S section 1363.05.
15. H&S, Article 4.5 of Chapter 2.2 of Division 2.
16. H&S sections 1367.002 – 1367.009.
17. H&S section 1367.010 – 1367.012.
18. H&S section 1367.02.
19. H&S section 1367.035.
20. H&S section 1367.042.
21. H&S section 1367.07 – 1367.1
22. H&S sections 1367.45 – 1367.46.
23. H&S section 1367.15.
24. H&S section 1367.23.
25. H&S section 1367.30.
26. H&S section 1368.2
27. H&S sections 1368.04 – 1368.05.
28. H&S section 1372.
29. H&S section 1373.5.
30. H&S sections 1373.621 – 1373.622.
31. H&S section 1373.7 – 1373.8.
32. H&S section 1373.95.
33. H&S section 1373.10.

34. H&S section 1373.14.
35. H&S section 1373.18.
36. H&S section 1374.
37. H&S sections 1374.5 – 1374.58.
38. H&S sections 1374.9 – 1374.10.
39. H&S, Article 5.5 of Chapter 2.2 of Division 2.
40. H&S, Article 5.55 of Chapter 2.2 of Division 2.
41. H&S sections 1374.65 – 1374.721.
42. H&S sections 1374.723 – 1374.76.
43. H&S sections 1375.1 – 1375.3.
44. H&S section 1376.
45. H&S section 1377.
46. H&S sections 1379.5 – 1380.
47. H&S section 1381.
48. H&S section 1383.
49. H&S section 1385.
50. H&S, Article 6.1 of Chapter 2.2 of Division 2.
51. H&S, Article 6.2 of Chapter 2.2 of Division 2.
52. H&S, Article 7 of Chapter 2.2 of Division 2.
53. H&S sections 1389.1 – 1389.7.
54. H&S, Article 8 of Chapter 2.2 of Division 2.
55. H&S, Article 8.5 of Chapter 2.2 of Division 2.
56. H&S sections 1395.6.H&S sections 1399.5.
57. H&S section 1399.57.
58. H&S, Article 10 of Chapter 2.2 of Division 2.
59. H&S, Article 10.2 of Chapter 2.2 of Division 2.
60. H&S, Article 11 of Chapter 2.2 of Division 2.
61. H&S, Article 11.1 of Chapter 2.2 of Division 2.
62. H&S, Article 11.5 of Chapter 2.2 of Division 2.
63. H&S, Article 11.8 of Chapter 2.2 of Division 2.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

1.0 Definitions

As used in this Exhibit L of this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms governs the construction of this Contract:

California Children Services (CCS) Provider means any of the following Providers when used to treat Members for a CCS condition:

A. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS program.

C. A special care center approved by the CCS program.

Specialized Durable Medical Equipment means DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a Physician's description and orders; is made to order or adapted to meet the specific needs of the beneficiary; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

2.0 EXHIBIT L OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

	Operational Readiness Requirement
Exhibit L 1	Submit a written transition plan detailing the transfer of case management, Care Coordination, Provider referral, and service authorization administrative functions of the California Children's Services (CCS) program to Contractor to be prepared by the designated county agency and Contractor. The transition plan must include the following: 1) Detailed process for completing all required risk assessments, including telephonic or in-person communications and, for CCS-eligible Members determined to be high risk, all required Individual Care Plans (ICPs) within one year for Whole-Child Model (WCM) transition Members. 2) Process for verifying that approved Subcontractors and Downstream Subcontractors that are delegated risk and are responsible for arranging for the provision of Covered Services are compliant. Refer to All Plan Letter (APL) 21-005 WCM Section: Risk Level and Needs Assessment Process for direction on required deliverable updates. 3) Detailed Dispute Resolutions Policy stating that disagreements between Contractor and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS. Refer to APL 21-005 WCM Section: Dispute Resolution and Provider Grievances for direction on required deliverable update.
Exhibit L 2	Submit the executed WCM Memorandum of Understanding (MOU) or evidence indicating a reasonable effort to finalize the MOU with the county CCS program. Additionally, the MOU must address Contractor and CCS coordination with regards to Medical Therapy Unit services.
Exhibit L 3	Submit a Provider network that includes an appropriate number of CCS Providers adequate to serve the needs of CCS-eligible Members in the Service Area.
Exhibit L 4	Submit an updated Provider network via the Provider Network Readiness template. Contractor must complete and submit the provided template and include additional contracted CCS-paneled Providers, allied and medical supportive personnel, Durable Medical Equipment (DME) Providers, and approved Provider facilities, including: Specialists, Tertiary and Pediatric

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	Community Hospitals, Neonatal Intensive Care Units, and Special Care Centers.
Exhibit L 5	Submit policies and procedures to ensure continuity of care for CCS-eligible Members with their CCS Providers, Specialized Durable Medical Equipment Providers, and Prescription Drugs.
Exhibit L 6	Submit updated policies and procedures that outline Continuity of Care (COC) for CCS-Medically Necessary services, including the following: 1) COC for CCS-eligible Members to receive services outside of Contractor's Subcontractor if there is a WCM network certification deficiency within Contractor's Subcontractor Network. 2) COC is allowed for CCS-eligible Members to continue to receive services from their previous DE, including their assigned PCP, for those who are required to select or be reassigned to a new DE. Contractor and its Subcontractors and Downstream Subcontractors must comply with COC requirements outlined in APL 22-032 and APL 21-005.
Exhibit L 7	Submit Provider network analysis to demonstrate the availability of an appropriate Provider network to serve the needs of CCS Members, including Primary Care Providers (PCP), pediatric Specialists and sub-Specialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, special care centers, and DME Providers.
Exhibit L 8	Submit Contractor's standard, monthly 274 file(s) to the PACES production environment to confirm that the proposed Provider network supplied through the Provider Network Readiness template was realized via executed contracts, and the Provider network meets the needs of CCS Members.
Exhibit L 9	Submit an attestation that Contractor and its Subcontractors and Downstream Subcontractors will work to execute contracts with all Providers included on the updated Provider Network Readiness template submission.
Exhibit L 10	Submit updated policies and procedures for ensuring Subcontractors and Downstream Subcontractors fully comply with all the terms and conditions of this Contract with WCM network certification requirements including: 1) Policies and procedures for ensuring Subcontractors and Downstream Subcontractors meet WCM operational requirements included in the contract as well as APL 21-005. 2) Process for ensuring a Subcontractor and Downstream Subcontractor meets WCM network certification requirements.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	3) Oversight and readiness activities for Subcontractors and Downstream Subcontractors for Phase 2 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures of review process for Subcontractors and Downstream Subcontractors 4) Oversight and enhanced readiness activities for Subcontractors and Downstream Subcontractors for Phase 3 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures review process for Subcontractors and Downstream Subcontractors.
Exhibit L 11	Submit updated policies and procedures to ensure that credentialing and re-credentialing includes and speaks to CCS Providers.
Exhibit L 12	Submit attestation that no CCS-eligible Members will be enrolled or assigned to a Subcontractor and Downstream Subcontractor that is excluded from participating in WCM and that Contractor will allow Members access to CCS-paneled providers within all of Contractor's Provider network for CCS services. Provide process for how Contractor will ensure that that no CCS-eligible Members will be enrolled or assigned to a DE that is excluded from participating in WCM.
Exhibit L 13	Submit updated policies and procedures to include details surrounding the processes by which a CCS-eligible Member may maintain access to a Provider or a Specialized DME Provider for up to 12 months. The policy and procedure must endure the following: 1) COC requirements for pharmaceutical services and the provision of prescribed drugs, as described in contract Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to CCS-eligible Members. 2) Contractor must send a written notice to the Member 60 days before the 12-month authorization expires. 3) Allow a CCS-eligible Member, or a family member or caregiver of a CCS beneficiary, to appeal the continuity of care 12-month limitation to the Director or their designee.

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Exhibit L 14	Submit updated policies and procedures to explain the approach and development of ICPs for CCS-eligible Members based on the results of the pediatric health risk assessment process. ICPs must be completed with a particular focus on CCS specialty care, consider behavioral health needs, and must coordinate those services. If needed, Contractor must facilitate a CCS-eligible Member's ability to access appropriate community resources and other agencies, including referrals for behavioral services such as Specialty Mental Health Services and Substance Use Disorder services. The policies and procedures must include access for families to know where to go for ongoing information, education, and support so that they understand the goals, treatment plan, and course of care for their Child and their role in the process, what it means to have primary or specialty care for their Child, when it is time to call a PCP, Specialist, urgent care, or emergency room, what an interdisciplinary care team is, and what the community resources are. Risk Level and Needs Assessment. Refer to APL 21-005 WCM Section: Risk Level and Needs Assessment Process, for direction on required deliverable updates.

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3.0 Whole Child Model Program

3.1 Whole Child Model Scope of Services
3.2 Required Reports for the Whole Child Model Program
3.3 Data Sharing Links
3.4 Whole Child Model Payments

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3.1 Whole Child Model Scope of Services

3.1.1 Whole Child Model Program Compliance

Contractor agrees to implement the Whole Child Model (WCM) program, as directed by DHCS and in accordance with Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) and All Plan Letter (APL) 21-005, in order to cover benefits that were previously covered by the California Children's Services (CCS) program. Contractor's implementation of and participation in the WCM program renders this Contract's requirements around CCS, as stated in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), and elsewhere in this Contract, inapplicable to Contractor.

A. Contractor must provide all Medically Necessary services previously covered by the CCS program as Covered Services for Members who are eligible for the CCS program at the time of the transition of benefits to Contractor, and for Members who are determined eligible for CCS after the transition of benefits.

B. To ensure consistency in the provision of covered CCS, Contractor must use all current and applicable CCS program guidelines, including CCS program regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by Contractor's Medical Director or the equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Contractor must use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-eligible condition.

   The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

   http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

C. Contractor must be responsible for all available Medically Necessary Medi-Cal services. Any Medically Necessary CCS services not available as a Medi-Cal Covered Service must remain the responsibility of the State and the county.

D. Contractor must submit its written transition plan to DHCS before commencing the transition to the Whole Child Model. The transition plan will detail how Contractor will transition CCS-eligible Members from the

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county CCS program to the Whole Child Model, and take over responsibility for case management, care coordination, Provider referrals, and service authorizations for Members who are enrolled in the CCS program at the time of the transition, in accordance with Health and Safety Code (H&S) section 123850(b)(1) and APL 21-005.

E. Contractor must provide DHCS with documentation confirming that a local stakeholder process has been established in accordance with Welfare and Institutions Code (W&I) section 14094.7(d)(3). Such documentation may include meeting minutes, a meeting schedule, or other forms of confirmation approved by DHCS.

F. Contractor must execute a MOU with the county CCS program as stipulated in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), for the coordination of CCS services to Members. This MOU must include the following:

1) Agreements on the transition of Care Coordination and service authorization for CCS from the county CCS program to Contractor, and how Contractor will work with the county CCS program to ensure continuity and consistency;

2) Policy and procedures for referral to and coordination with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services provided under this Contract;

3) A provision to allow a Member eligible for CCS to continue to receive care management and Care Coordination from their current CCS public health nurse, unless this requirement is waived by DHCS in accordance with W&I section 14094.13(h). The Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, must make the request to continue with their current CCS public health nurse within 90 days of their transition to the Whole Child Model, in accordance with W&I section 14094.13(e) and (f).

3.1.2 Annual Medical Eligibility Redeterminations

A. Contractor must provide all necessary documentation, dated within the last six months but no later than 12 months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility

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redetermination by the county CCS program. This includes but is not limited to:

1) The Member's current medical records that document the Member's medical history;

2) Results of physical examinations by a Physician;

3) Laboratory test results;

4) Radiologic findings; and

5) Other tests and examinations that support the diagnosis of the eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

B. Contractor must provide the documentation to the county CCS program no later than 60 calendar days before the Member's CCS program eligibility end date. If documentation is received after the 60-day timeframe, Contractor and the county CCS program should collaborate to determine the best approach for submitting documents.

C. If the county CCS program requires additional documentation, Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

D. Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.

E. For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

3.1.3 CCS Advisory Committees

A. Contractor must create and maintain a CCS clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity

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Committee described in Exhibit A, Attachment III, Section 2.3 (*Quality Improvement and Health Equity Committee*). The CCS clinical advisory committee must be composed of Contractor's Medical Director or the equivalent, the county CCS medical director, and at least four CCS-paneled Providers.

1) The CCS clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

2) The CCS clinical advisory committee must meet at least quarterly, or more frequently if determined necessary.

B. Contractor must establish a CCS family advisory group that is separate and distinct from its Community Advisory Committee described in Exhibit A, Attachment III, Subsection 5.2.11.E (*Cultural and Linguistic Programs and Committees*), and is specifically for CCS families.

1) The CCS family advisory group must be comprised of CCS-eligible Members' parents, custodial parents, legal guardians, or other Authorized Representatives. Family representatives who serve may receive a reasonable per diem payment to enable in-person participation in the CCS family advisory group.

2) Contractor may conduct CCS family advisory group meetings at least quarterly and utilize teleconference or other similar electronic means to facilitate participation.

3) A representative of the CCS family advisory group must be invited to serve on the DHCS statewide stakeholder advisory group for CCS.

3.1.4 CCS Provider Network

A. Contractor must include in their Network an adequate number of CCS Providers able to serve the needs of Members with CCS conditions and receive timely access. Contractor must utilize only paneled CCS Providers to treat CCS conditions when a CCS-eligible Member's condition requires treatment from the Provider types described in this Provision. DHCS remains responsible for paneling CCS Providers. Contractor may use an out-of-state Provider, in accordance with APL 19-004, if an in-state CCS

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Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition.

B. In addition to the Network requirements found in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*), Contractor must also include the following:

1) An adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

2) Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

3) That among the pediatric Network Providers are an adequate number of CCS-paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

C. In addition to the requirements in Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), Contractor must credential CCS Providers in accordance with APL 21-005.

D. CCS Providers must be able to utilize Contractor's Provider Dispute Resolution Mechanism, as described in Exhibit A, Attachment III, Section 3.2.2 (*Provider Dispute Resolution Mechanism*).

3.1.5 Provider Compensation

In addition to the requirements found in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*), Contractor must also reimburse Physicians and surgeons providing CCS to eligible Members at rates that are equal to or exceed the applicable CCS Fee-For-Service (FFS) rates, unless the Physician and surgeon enters into an agreement on an alternative payment methodology mutually agreed to by the Physician and surgeon and Contractor.

3.1.6 Covered Services

In addition to the requirements found in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover CCS for Members determined to be eligible in accordance with the CCS program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS-

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eligible condition, Contractor must refer the Member to the county CCS office for eligibility determination.

A. Contractor must ensure assessment and Care Coordination for the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, as required below in Exhibit L, Subsection 3.1.9 (*Care Management and Coordination of Care*).

B. For the identification of a Member eligible for CCS, Contractor must ensure the following:

1) Network Providers must perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS-eligible medical condition.

2) Initial referrals of Member's with CCS-eligible conditions must be made to the county CCS program by telephone, same day mail, or fax or other secure electronic system, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS program.

3) Contractor must provide all Medically Necessary CCS Covered Services for the Member's CCS-eligible condition(s).

4) If the county CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member, including Early Periodic Screening, Diagnosis and Testing (EPSDT) as required in Exhibit A, Attachment III, Subsection 5.3.4.F (*Services for Members Less Than 21 Years of Age*).

3.1.7 Continuity of Care

Contractor must provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with W&I sections 14094.13, H&S section 1373.96, APL 21-005, and as follows:

A. In accordance with W&I section 14094.13(a)-(d), Contractor must ensure continuity of care between Members eligible for CCS and CCS Providers,

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and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition.

B. For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Contractor must provide continuity of care under the following conditions:

1) The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to the WCM program.

2) The Member has previously received Specialized Durable Medical Equipment from the Provider.

3) The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Contractor’s rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Contractor and the CCS Provider.

4) Contractor confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

5) The CCS Provider makes treatment information available to Contractor, to the extent authorized by the State and federal patient privacy provisions.

6) The Provider of Specialized Durable Medical Equipment makes information available as requested by Contractor, to the extent authorized by the State and federal patient privacy provisions.

7) At its discretion, Contractor may extend the continuity of care period beyond the 12 months specified in Paragraph C.1) above.

C. Ensure that the continuity of care requirements for Pharmaceutical Services and Provision of Prescribed Drugs described in Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to Members who are eligible for the CCS program at the time of the transition to the WCM program. Before the previously prescribed drug is discontinued, Contractor and the Member’s prescribing CCS Provider must complete the necessary evaluation and treatments, and must both agree that the previously prescribed drug is no longer Medically

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Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

D. For CCS neonatal intensive care units, Contractor must pay the Provider either the equivalent of Medi-Cal FFS rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Contractor's negotiated rate, whichever is higher, for up to 12 months after the transition.

3.1.8 EPSDT Services

For CCS-eligible Members, Contractor must provide all Medically Necessary Covered Services, including EPSDT services, as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*), when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Contractor must apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

3.1.9 Care Management and Coordination of Care

In addition to the requirements in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), and Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), Contractor must provide service authorization, case management, and Care Coordination for CCS by a primary point of contact with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a Member's eligibility for the CCS program is established, Contractor must complete the following for risk stratification and assessment, and coordination of care in accordance with APL 21-005:

A. For Members identified as eligible for CCS, Contractor must conduct a Risk Stratification and Segmentation (RSS) in accordance with the requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), and approved by DHCS to use for CCS-eligible Members. Based on the results of the health risk stratification, Contractor must then further assess CCS-eligible Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.

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B. For the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, Contractor must conduct a RSS in accordance with the requirements of this Contract.

C. As determined necessary by Contractor's RSS, Contractor must provide Complex Care Management Services as described in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*), to all Members eligible for CCS and coordinate care between the Primary Care Provider (PCP), CCS specialty services, and if applicable Non-Specialty Mental Health Services and Regional Center services across all settings. The provision of Complex Care Management must include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS, behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other Authorized Representatives.

D. Contractor must also arrange referral to Specialty Mental Health and Drug Medi-Cal services as appropriate through the county Substance Use Disorder (SUD) program if determined necessary through Contractor's RSS. To arrange services with a Regional Center, Contractor must:

1) Coordinate with Members eligible for CCS and their parents, custodial parents, legal guardians, or other Authorized Representatives, in understanding and accessing services; and

2) Operate as a central point of contact for questions regarding access, care, and problem resolution.

E. Contractor must create a Care Management Plan (CMP) for CCS-eligible Members who have been determined high risk through the RSS process, incorporate the required elements stated in W&I section 14094.11I and APL 21-005, be specific to individual Member needs, and update the CMP at least annually.

F. Provide Person-Centered Planning, as described in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care*), to Members eligible for CCS and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

G. Provide information to Members eligible for CCS on how to access local family resource centers or family empowerment centers.

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H. Allow a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request continuing case management and Care Coordination from their public health nurse within 90 days of transitioning to the WCM program, in accordance with W&I section 14094.13(e). If the county public health nurse leaves the CCS program or is no longer available to provide case management and Care Coordination, Contractor must transition those services to one of its case managers who has received adequate training on the CCS program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

I. If Contractor expands its CCS coverage area to other counties, Contractor must comply with CCS program standards including, but not limited to, referral standards as stated in W&I section 14093.06(a).

3.1.10 Rights for Members Eligible for CCS

A. Contractor must provide a mechanism for a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

B. For Members receiving continuity of care as stated in Provision 5, Paragraph C of this Attachment, Contractor must send a written notice 60 days prior to the end of the authorized continuity of care period. The notice must explain the right to petition Contractor for an extension of the continuity of care period, the criteria used to evaluate the petition, and the Appeals process if Contractor denies the petition.

C. In addition to the Member's right to file a Grievance or request an Appeal, State Hearing, or an Independent Medical Review if applicable, as stated in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*), Contractor must also ensure that Members who are eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, may Appeal the continuity of care limitations, or the extension of a continuity of care period, as stated in this Exhibit L, Subsection 3.1.6 (*Covered Services*), to the DHCS Director in accordance with W&I section 14094.13(i)(1).

D. Contractor must also ensure that CCS-eligible Members retain the right to request an Appeal and State Hearing for CCS eligibility and CCS service authorization denials.

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3.2 Required Reports for the Whole Child Model Program

In addition to the reporting requirements for Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) stated in Exhibit A, Attachment III, Section 7.0.(*Operations Deliverables and Requirements*), Contractor must also identify which Grievances and requests for Appeal were submitted by CCS-eligible Members.

3.3 Data Sharing Links

Contractor must establish and maintain communication links to allow interfaces with Children's Medical Services (CMS) Net and outside entities designated by DHCS.

3.3.1 Contractor must establish and maintain an agreement with the Office of Technology Services (Otech) within the California Department of Technology for an appropriate link between Contractor and Otech for the purpose of computer access for records contained in CMS Net and other Medi-Cal eligibility files that may be made available to Contractor. Upon connectivity with the authorized external entities, Contractor must retrieve information in a format to be determined by DHCS.

3.3.2 Contractor must comply with all data sharing requirements in Exhibit G of this Contract.

3.4 Whole Child Model Payments

Contractor must be paid a supplemental WCM monthly payment for each Member who is determined eligible for CCS. Payments for Members identified as CCS-eligible cannot exceed the rate as stated in Exhibit B, Section 1.3 (*Capitation Payment Rates*) and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. The payment period for the supplemental WCM payment must commence on the effective date of this Contract, January 1, 2024.

3.4.1 Contractor must receive the supplemental WCM payment in accordance with the conditions listed below.

A. The supplemental WCM payment must be in lieu of any other compensation for a CCS-eligible Member in any month.

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B. Contractor must be eligible to receive a supplemental WCM payment in the month in which a Member is determined to be eligible to receive CCS by the county CCS program.

3.4.2 If DHCS determines that a Member for whom Contractor received a supplemental WCM payment was not determined eligible for CCS in the month(s) for which supplemental WCM payment was made, DHCS must recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). DHCS must give Contractor 30 calendar days prior written notice of any such offset.

CY 2024-A Contract Amendment Detail

Category	Requirement	Regulatory and Sub-Regulatory Guidance
Network Provider Agreement Requirements	-Network Providers must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable. -Added that managed care plans (MCPs) must also file with DHCS all executed Downstream Subcontractor Agreements with Downstream Fully Delegated Subcontractors.	-All-Plan Letter (APL) 23-013: Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework -H&S section 130290
Enhanced Care Management – Justice Involved	-Ensure ECM Providers serving the Justice Involved (JI) Population of Focus meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the JI Initiative, including, but not limited to those outlined in Subsections 4.4.3.J, 4.4.6, and 4.4.7 of the contract. -Ensure network overlap of JI pre-release care management provider network and JI ECM Provider network across MCPs in the same county of operation. CalOptima Health must obtain prior DHCS approval of any exception requests from network overlap requirements for one of the permissible reasons as described in the JI Policy.	-Justice Involved Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative
Medical Loss Ratio (MLR)	-Added Subcontractors' and Downstream Subcontractors' to MLR reporting requirements. -Ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). -Calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS. -Review and provide oversight to Subcontractor MLR submissions. -Required references must be included in subcontracts. -DHCS utilizes a materiality threshold to determine whether Subcontractors are subject to the reporting and remittance requirements set forth by CMS in Section 1915(b) of the CalAIM waiver's STCs A11. -Subcontractor arrangements that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right	-42 CFR section 438.8 -42 CFR section 438.604(a)(3) -42 CFR section 438.6(d) -42 CFR section 438.230(c) -Section 1915(b) of the CalAIM waiver's STCs A11

	to reestablish the threshold annually and may require reporting by certain Subcontractors regardless of materiality. -DHCS will work with CMS to effectuate an audit of MLR reports no sooner than CY 2028 for the period January 1, 2022, through December 31, 2026.	
Justice Involved Reentry Coordination and Managed Care Liaison	-Maintain policies and procedures for coordinating with Correctional Facilities and pre – release care managers to support members leaving Correctional Facilities and reentering the community. -Have an assigned Justice Involved liaison for justice involved reentry coordination (which may be one individual or multiple identified individuals).	-Justice Involved Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative
County Child Welfare Liaison	-Clarified role of the liaison and revised name from "Foster Care" to "County Child Welfare" liaison, since it is intended to benefit members involved in child welfare not only those in foster care.	
Enhanced Care Management	-Maintain a list of ECM Providers in the MCP's Provider Directory.	-ECM Policy Guide
Community Support Data Sharing and Reporting Requirements	-Comply with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.	-APL 23-013: Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework -H&S section 130290
Population Health Management (PHM) and Population Needs Assessment (PNA)	-Updated requirements related to PNA and PHM Strategy, Transitional Care Services (TCS), and Targeted Case Management (TCM) services to align with the current PHM Policy Guide. -Review and update cultural and linguistic services programs to align with the PNA implementation and subsequent findings. -Following NCQA requirements, MCPs may delegate Complex Care Management (CCM) to Network Providers or other entities that are NCQA-certified.	-PHM Policy Guide -APL 22-024: Population Health Management Program Guide -APL 23-021: Population Needs Assessment and Population Health Management Strategy

Scope of Services		
	-Ensure that pregnant Members are informed about Doula coverage. Also, ensure that pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and ensure access to genetic screening with appropriate referrals. -Cover doula services as outlined in Subsection 5.3.6.C of the contract and APL 23-024.	-42 CFR Section 440.130(c) -APL 23-024: Doula Services
	-Clarified that Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC) *or DHCS-approved Centers of Excellence*.	-APL 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the CalAIM Initiative -DHCS Provider Manual
	- Ensure that Members in need of Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), ICF/DD-H, and ICF/DD-N services are placed in the ICF/DD Home deemed most appropriate to the Member's medical needs as specified in the Individualized Program Plan (IPP) issued by the Member's Regional Center.	-APL 23-023: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
	- Cover routine patient care costs for Members participating in a qualifying clinical trial as outlined in Subsection 5.3.8.B of the contract.	-42 USC section 1396d(a)(30) -W&I section 14132.98
Special Contract Provisions Related to Payment	-Clarified that the MCP must pay eligible contracted and non-contracted Providers amounts equivalent to the California Medicaid State Plan approved rates, *or amounts equivalent to the rates published by DHCS for University of California system facilities furnishing subject services*, for specified organ and bone marrow transplant services.	-APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the CalAIM Initiative -Directed Payment Initiative preprint -W&I section 14184.201(d)
	-Comply with the terms of the Quality Withhold and Incentive Program requirements outlined in Subsection 1.1.14, Exhibit B, of the contract.	-42 CFR section 438.6(b)(2)
	-Comply with FQHC Alternative Payment Model Risk Corridor requirements outlined in Subsection 1.1.20, Exhibit B, of the contract.	-W&I section 14138.16
	-The Unsatisfactory Immigration Status Risk Corridor will be in effect for each of the rating periods covering	

	dates of services from January 1, 2024, through December 31, 2024, as outlined in Subsection 1.1.21, Exhibit B, of the contract.	
Quality Improvement and Health Equity Annual Plan	-Clarified that the annual QI and Health Equity plan submitted by MCPs must be developed through regional quality and health equity teams. -Attend regional collaborative meetings which may include additional regional partners.	-DHCS Comprehensive Quality Strategy -APL 24-004: Quality Improvement and Health Equity Transformation Requirements
External Quality Review Requirements	-Clarified that MCPs must meet *or exceed* DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS.	-APL 23-012: Enforcement Actions: Administrative and Monetary Sanctions -APL 19-017: Quality and Performance Improvement Requirements
Community Health Workers (CHW)	-Removed requirement to have approved and operable P&Ps by October 1, 2024, to provide the CHW benefit within contracted hospitals offering Emergency Services.	-APL 24-006: Community Health Worker Services Benefit
Non-specialty Mental Health Services and Substance Use Disorder (SUD) Services	-Cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member as outlined in Subsection 5.5.2.I of the contract.	-22 CCR section 53855 -APL 22-005: No Wrong Door for Mental Health Services Policy -Behavioral Health Information Notice (BHIN) 22-011
Network and Access to Care	-Re-inserted requirement (that was erroneously removed from 2024 contract) to include within the MCP's network every CBAS provider within the service area that has been approved by CDA as a CBAS provider when the conditions in Subsection 5.2.3.K are met.	
Claims Processing	-Added language regarding interest charges for untimely payments.	-APL 23-020: Requirements for Timely Payment of Claims -H&S section 1371(a)
MOU Requirements	-Comply with updated MOU requirements outlined in Subsection 5.6 of the contract.	-APL 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities
Data Exchange	-Exchange data in compliance with the terms of this contract during and after expiration of the contract as outlined in Subsection 1.1.37.	-APL 23-013: Mandatory Signatories to the California Health and Human Services

		Agency Data Exchange Framework -W&I Code Section 14138.16.
Provider Dispute Resolution Mechanism	-Removed language regarding extensions to the dispute resolution timeframe that conflicted with Knox-Keene Act.	-H&S section 1371.35
Miscellaneous Updates	-Updated terms and acronyms used in the agreement. -Updated regulatory and APL citations. -Clarified and corrected language as necessary. -Updated Exhibit A, Attachment II – 1.0 Operational Readiness Deliverables and Requirements. -Updated Exhibit A, Attachment III – 7.0: Operations Deliverables and Requirements	

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

8. Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Ratify the following list of qualifying funding partners and allocations for participation in the Calendar Year 2023 Voluntary Rate Range Intergovernmental Transfer Program:

1. City of Fountain Valley Fire Department;
2. City of Huntington Beach Fire Department;
3. City of Orange Fire Department;
4. City of Newport Beach Fire Department;
5. Children and Families Commission of Orange County (First 5 of Orange County);
6. County of Orange Health Care Agency; and
7. University of California, Irvine.

Background

The Voluntary Rate Range Intergovernmental Transfer (IGT) program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, eligible entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions. CalOptima Health currently retains a 2% administrative fee of net proceeds for administration of the Voluntary Rate Range IGT program.

On May 29, 2024, DHCS notified CalOptima Health regarding the Calendar Year (CY) 2023 Voluntary Rate Range IGT program opportunity with up to $52.5 million in contribution for Orange County. CalOptima Health's submission of the required materials was due to DHCS by July 10, 2024. At the June 6, 2024, Board of Directors meeting, staff received approval to pursue funding partnerships with eligible entities, submit the proposal to DHCS, execute agreements with the funding entities, and bring back the final list of funding partners and allocation at the August 1, 2024, Board of Directors meeting.

Discussion

CalOptima Health contacted the six CY 2022 Voluntary Rate Range program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT

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program timeline and funding availability. CalOptima Health also reached out to the City of Fountain Valley as they had recently inquired and expressed interest in participating.

CalOptima Health submitted the proposal to DHCS, along with the proposed funding entities' supporting documents, on July 8, 2024. The entities and their approximate contribution amounts are:

Funding Entity	Calendar Year 2023 Total Transfer Amount	Calendar Year 2023 Total Participation Percentage (%)
Children & Families Commission of Orange County (First 5 of Orange County)	$804,153	1.53%
City of Fountain Valley Fire Department	$779,540	1.48%
City of Huntington Beach Fire Department	$2,292,744	4.36%
City of Newport Beach Fire Department	$367,822	0.70%
City of Orange Fire Department	$579,294	1.10%
County of Orange Health Care Agency	$3,547,480	6.75%
University of California, Irvine	$44,180,379	84.07%
Total Funding Entities Participation	$52,551,412	100%
Unfunded	$0	0%
Total Available Non-federal Share IGT	$52,551,412	-

Due to the timing of the submission, CalOptima Health staff request the Board of Directors ratify the list of funding partners and the funding allocations above that were submitted for the CY 2023 Voluntary Rate Range IGT to DHCS on July 8, 2024.

Fiscal Impact
The recommended action is net budget neutral and has no additional fiscal impact.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements allows Orange County eligible funding partners to participate in the CY 2023 Voluntary Rate Range IGT program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated June 6, 2024, Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023.
3. CalOptima Health Calendar Year 2023 Voluntary Rate Range Program Letter of Interest and Proposal to DHCS.
4. CY 2023 DHCS Attachment C CalOptima Health Estimated Funding Allocation.

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708
City of Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange Fire Department	300 E. Chapman Avenue	Orange	CA	92866
County of Orange Health Care Agency	405 W. 5th Street, Suite 756	Santa Ana	CA	92701
First 5 Orange County Children & Families Commission	1505 E. 17th Street, Suite 230	Santa Ana	CA	92705
University of California, Irvine Medical Center	101 City Drive, Bldg 53, Suite 100	Orange	CA	92868

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023

Contact
Donna Laverdiere, Executive Director, Strategic Development (714)-986-6981

Recommended Actions
Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2023 (IGT 13):
1. Submission of a proposal to the California Department of Health Care Services to participate in IGT 13;
2. Pursuit of funding partnerships with eligible participating entities; and
3. The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek IGT 13 funds.

Background
The Voluntary Rate Range IGT program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions.

CalOptima Health retains a 2% administrative fee of net proceeds to offset expenses for the administration of the Voluntary Rate Range IGT program.

Discussion
On May 29, 2024, CalOptima Health received notification from DHCS regarding the IGT 13 opportunity with up to $160.5 million in total funding availability for Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than June 28, 2024.

CalOptima Health will contact the six CY 2022 program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT program timeline and funding availability. CalOptima Health will also reach out to additional potentially eligible funding partners to inform them of the program timeline and requirements.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 13 and to authorize the Chief Executive Officer to enter into agreements with each of the identified

funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. Staff will submit to the Board the final list of funding partners and allocations for ratification at the August 1, 2024, meeting of the Board.

Fiscal Impact
Staff anticipates IGT 13 will be net budget neutral to CalOptima Health. CalOptima Health will retain a 2% administrative fee of net proceeds or approximately $1.95 million to offset expenses for the administration of the program. The remaining net proceeds will be distributed to the participating IGT funding entities.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2023. It will increase dollars to funding entities in Orange County to support Medi-Cal services to CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter
2. CY 2023 DHCS Attachment B Voluntary Rate Range Program – DHCS Template
3. CY 2023 DHCS Attachment C – CalOptima Health Estimated Funding Allocation
4. CY 2023 Voluntary Rate Range Letter of Intent Template
5. Prior Year – CY 2022 Voluntary Rate Range Program Participating Entities

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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Michelle Baass | Director

May 13, 2024

Peter Bastone
Chief Strategy Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year (CY) 2023 (January 1, 2023 – December 31, 2023) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Peter Bastone:

The Calendar Year 2023 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2023, through December 31, 2023.

DHCS shall not direct the MCP's expenditure of payments received under the CY 2023 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

California Department of Health Care Services
Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413
Sacramento, CA, 95899-7413
MS 4413 | Phone (916) 345-7070 | Fax (916) 650-6860
https://www.dhcs.ca.gov/

DHCS shall continue to administer all aspects of the IGT related to the CY 2023 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2023:

MCPs should refer to the estimated CY 2023 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the CY 2023 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated contribution (Non-Federal Share) amounts are based on CY 2023 capitation rates delivered to plans in May 2024, and actual member months (as of March 2024). Actual amounts may change based on finalized rates and updated enrollment information.

If an MCP elects to participate in the CY 2023 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

<u>Soliciting Interest</u>

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the CY 2023 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

<u>Submission Requirements</u>

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **<u>proposal</u>** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on **<u>MCP letterhead</u>**.
    2. The MCP's primary contact(s) information (name(s), title(s), e-mail address(s), mailing address(s), and phone number(s)).

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3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for CY2023. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the CY 2023 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A (included below) must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2023 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by **Friday, June 28, 2024**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *June 28, 2024***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, Michael.Ha@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the CY 2023 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the CY 2023 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

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Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

Michael Jordan
Staff Services Manager II
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachments

cc: Vivian Beeck
Staff Services Manager I
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Michael Ha
Health Program Specialist
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Scott Gale
Associate Governmental Program Analyst
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:
County:
Health Plan:

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: ______________________

Signature & Date: ______________________

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Voluntary Rate Range Program
Attachment C
January 1, 2023 - December 31, 2023

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 23 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,472,048	99.09	$ 106.27	$ 7.18	$ -	$ 7.18	$ 24,929,305	$ 10,525,551	42.22%
506	CalOptima	Orange	Child	UIS	148,873	32.09	$ 34.73	$ 2.64	$ -	$ 2.64	$ 393,025	$ 177,141	45.07%
506	CalOptima	Orange	Adult	SIS	1,423,569	212.50	$ 225.70	$ 13.20	$ -	$ 13.20	$ 18,791,110	$ 8,573,220	45.62%
506	CalOptima	Orange	Adult	UIS	267,683	178.51	$ 189.06	$ 10.55	$ -	$ 10.55	$ 2,824,056	$ 1,254,778	44.43%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,773,376	304.58	$ 322.43	$ 17.85	$ 4.46	$ 13.39	$ 50,525,505	$ 5,052,550	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	419,435	292.09	$ 308.77	$ 16.68	$ 4.17	$ 12.51	$ 5,247,132	$ 575,180	10.96%
506	CalOptima	Orange	SPD	SIS	442,469	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 20,397,821	$ 9,515,885	46.65%
506	CalOptima	Orange	SPD	UIS	86,182	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 3,595,513	$ 1,661,790	46.22%
506	CalOptima	Orange	SPD/Full-Dual	SIS	1,299,679	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 20,807,861	$ 9,720,739	46.72%
506	CalOptima	Orange	SPD/Full-Dual	UIS	6,355	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 44,104	$ 20,604	46.72%
506	CalOptima	Orange	LTC	SIS	2,597	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 119,722	$ 55,930	46.72%
506	CalOptima	Orange	LTC	UIS	1,559	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 65,041	$ 30,381	46.71%
506	CalOptima	Orange	LTC/Full-Dual	SIS	31,893	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 510,607	$ 238,539	46.72%
506	CalOptima	Orange	LTC/Full-Dual	UIS	124	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 861	$ 402	46.69%
506	CalOptima	Orange	Whole Child Model	SIS	133,436	1,761.91	$ 1,852.98	$ 91.07	$ -	$ 91.07	$ 12,152,017	$ 5,094,006	41.92%
506	CalOptima	Orange	Whole Child Model	UIS	4,171	552.77	$ 583.55	$ 30.78	$ -	$ 30.78	$ 128,383	$ 54,716	42.62%
506	**CalOptima**	**Orange**	**All COAs**		**11,513,449**	**287.15**	**$ 302.71**	**$ 15.56**	**$ 8.63**	**$ 13.94**	**$ 160,532,063**	**$ 52,551,412**	**32.74%**

Footnotes:
1 The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 23 MM effective as of March 2024.

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SHOULD BE DONE ON YOUR LETTER HEAD

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $________ for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, title, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment 5 – Prior Year CY 2022 Voluntary Rate Range Program Participating Entities

Legal Name	Address	City	State	Zip code
City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Children and Families Commission of Orange County (First 5 Orange County)	1505 E 17th Street, Suite 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Regents of the University of California, Irvine Medical Center (UCI Health)	333 City Blvd. West, Suite 200	Orange	CA	92868

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

July 3, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter is to confirm CalOptima Health's interest in initiating IGT for Calendar Year 2023 (January 1, 2023 through December 31, 2023) to enhance services for CalOptima Health's Medi-Cal members.

CalOptima Health is applying for the maximum amounts with one new funding entity (City of Fountain Valley) in addition to the previous participants. For Orange County's proposed IGT transaction for Calendar Year 2023, these funding entities have confirmed their participation as follows:

Funding Entity	**Calendar Year 2023 Total Transfer Amount**	**Calendar Year 2023 Total Participation Percentage (%)**
Children & Families Commission of Orange County (First 5 of Orange County)	$804,153	1.53%
City of Fountain Valley	$779,540	1.48%
City of Huntington Beach	$2,292,744	4.36%
City of Newport Beach	$367,822	0.70%
City of Orange	$579,294	1.10%
County of Orange Health Care Agency	$3,547,480	6.75%
UC Irvine Medical Center	$44,180,379	84.07%
Total Funding Entities Participation	$52,551,412	100.00%
Unfunded	$0	0%
Total Available Non-Federal Share IGT	$52,551,412	

The seven funding entities are able to contribute up to $52,551,412, or 100 percent of the non-federal share IGT amount for Orange County. The unfunded portion is $0, or 0 (zero) percent of the non-federal share IGT amount. CalOptima Health intends to retain 2% of the transaction as an administrative fee.

Enclosed, please find the attachments as requested for each funding entity:

- Voluntary, non-binding letter of interest including:
  - Dollar amount to be contributed as non-federal share IGT
  - Funding entity contact information
  - Funding entity's Federal I.D. number
- Separate attachment for Calendar Year 2023 including the following data from July 1, 2021–June 30, 2022:
  - Inpatient/Outpatient charges, as applicable
  - Inpatient/Outpatient costs, as applicable
  - Payments for Inpatient/Outpatient services, as applicable
  - Unreimbursed costs for Inpatient/Outpatient services, as applicable scope of services

The point of contacts for CalOptima Health are:

Mr. Mike Wood
Manager, Regulatory Affairs & Compliance (Medi-Cal Regulatory Affairs)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: mwood@caloptima.org
Phone: 714-246-8415

Ms. Annabel Vaughn
Director, Regulatory Affairs & Compliance (Medi-Cal)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: avaughn@caloptima.org
Phone: 714-246-8676

Mr. John Tanner
Chief Compliance Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: john.tanner@caloptima.org
Phone: 657-235-6997

Ms. Nancy Huang
Chief Financial Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: nhuang@caloptima.org
Phone: 657-235-6935

Mr. Jason Kaing
Controller
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: jason.kaing@caloptima.org
Phone: 657-900-1373

Ms. Donna Laverdiere
Executive Director, Strategic Development
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: donna.laverdiere@caloptima.org
Phone: 714-986-6981

Please contact Mr. Mike Wood (primary contact) if you have any questions regarding this submission.

Sincerely,

Michael Hunn
Chief Executive Officer

Enclosures

cc:
Vivian Beeck, Staff Services Manager, California Department of Health Care Services
Michael Ha, Health Program Specialist, California Department of Health Care Services
Michael Jordan, Staff services Manager II, California Department of Health Care Services
Scott Gale, Associate Governmental Program Analyst, California Department of Health Care Services
Chad Lefteris, Chief Executive Officer, UC Irvine Health
Christopher Leo, Director Government Affairs, UC Irvine Health
Anza Vang, Deputy Chief of Public Health Services, Orange County Health Care Agency
William McQuaid, Fire Chief, City of Fountain Valley
Tim Saiki, Battalion Chief, City of Fountain Valley

Scott Haberle, Fire Chief, City of Huntington Beach
Jeffrey Lopez, Division Chief of Operations, City of Huntington Beach
Bonnie To, Principal Management Analyst, City of Huntington Beach
Bryan Johnson, EMS Manager, City of Orange
Nathalia Flores, Administrative Analyst, City of Orange
Jeff Boyles, Fire Chief, City of Newport Beach
Kristin Thompson, EMS Division Chief, City of Newport Beach
Raymund Reyes, Administrative Manager, City of Newport Beach
Kimberly Goll, Executive Director, First 5 Orange County Children & Families Commission
Yunkyung Kim, Chief Operating Officer, CalOptima Health
Nancy Huang, Chief Financial Officer, CalOptima Health

1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
714-834-5310 first5oc.org

LETTER OF INTEREST

June 25, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the Children and Families Commission of Orange County (DBA First 5 Orange County), a governmental entity, federal I.D. Number 95-6000928, in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of January 1, 2023, through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The Children and Families Commission of Orange County is willing to contribute approximately $804,153 for the Calendar Year 2023 (January 1, 2023 - December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kimberly Goll, President CEO
Children and Families Commission of Orange County
1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
(714) 920-2598
Kim.Goll@cfcoc.ocgov.com

You may also contact our consultant, Gelmy Ruiz, with any questions or concerns regarding our participation in the IGTs. Her contact information is (916) 329-8234 or gruiz@healthmanagement.com.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Kimberly Goll
President/CEO

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	Children and Families Commission of Orange County
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other		$ 930,973.14		$ -	$ 930,973.14
Total	$ -	$ 930,973.14	$ -	$ -	$ 930,973.14

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? **Yes**

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The Children and Families Commission of Orange County (First 5 Orange County) health care services are provided to children aged 0-5 and their caregivers and encompass pre and post-natal maternal health screenings; postpartum depression screening and referrals; lactation education and aid; parenting education; case management, care coordination, and referrals to home visits to support the at-risk, postpartum population; and the provision of development assessments and screenings to identify children with autism and neurodevelopmental disorders. First 5 Orange County does not have a contract with CalOptima for services.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: Children and Families Commission of Orange County

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County Commission

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Tobacco tax revenue collected by the State and distributed to Counties based on birthrates to develop, adopt, promote, and implement local early children development programs.

(iv) Does the transferring entity have general taxing authority? **No**

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

Yes, 80% of revenue collected is distributed to counties.

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Kimberly Goll, President/CEO

Signature & Date: Kimberly Goll

Back to Agenda Back to Item

10200 Slater Avenue
Fountain Valley, CA 92708
Phone: (714) 593-4412
Fax: 714-593-4494
fountainvalley.gov

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Fountain Valley, a governmental entity, Federal I.D. Number 95-2158356 (NPI: 1528109212), in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Fountain Valley is willing to contribute approximately $779,540 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:
William McQuaid, Fire Chief
10200 Slater Avenue
Fountain Valley, CA 92708
Email – bill.mcquaid@fountainvalley,gov
Office (714) 593-4436
Cell (714) 336-6844

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

6/27/24

William McQuaid
Fire Chief

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Fountain Valley
County:	Orange County, CA
Health Plan:	CalOptima Health

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 894,656.97	$ 680,781.45	$ 115,116.04	$ 779,540.93	$ 565,665.41
Total	$ 894,656.97	$ 680,781.45	$ 115,116.04	$ 779,540.93	$ 565,665.41

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The City of Fountain Valley provides 911-response to medical calls, traffic accidents, and other emergencies requiring emergency medical care. The City's service model includes Advance Life Support (ALS) response daily via 3 fire apparatus (two engines, one ladder truck) with 1 company officer, 1 fire engineer, and 2 firefighter/paramedics each. It also includes two Basic Life Support (BLS) ambulances daily with 2 emergency medical technitions (EMTs) on each ambulance.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Fountain Valley

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds: General Fund

(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

CalOptima charges and payments provided via billing report from our contracted billing provider (Wittman). Costs calcuated using Fiscal Year 21/22 actual budget, CalOptima transport statistics from Wittman, and CAD data (call volume).

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: William McQuaid Fire chief

Signature & Date: [signature] 6/27/2024

Back to Agenda Back to Item

HUNTINGTON BEACH FIRE DEPARTMENT

2000 Main Street
California 92648

Phone: (714) 536-5411
www.huntingtonbeachca.gov

Scott M. Haberle
Fire Chief

June 24, 2024

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services 1501
Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Huntington Beach, a governmental entity, federal I.D. Number 95-6000723, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Huntington Beach is willing to contribute approximately $2,292,744.47 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP, and DHCS on this issue:

Scott Haberle, Fire Chief
2000 Main Street, Huntington Beach, CA 92648
Office: 714-536-5401, Email: scott.haberle@surfcity-hb.org

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Scott M. Haberle

"Smoke Detectors Save Lives"

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Huntington Beach Paramedic Services, NPI 1568467264			
County:	Orange County, CA			
Health Plan:	Mcal HMO CalOptima			

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 2,786,447.41	$ 2,677,407.00	$ 493,702.94	$ 2,292,744.47	$ 2,183,704.06
Total	$ 2,786,447.41	$ 2,677,407.00	$ 493,702.94	$ 2,292,744.47	$ 2,183,704.06

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

We provide first responder, BLS, and full ALS 911 response and medical transport services to CalOptima patients with no contractual arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Huntington Beach

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The City of Huntington Beach general fund revenues.

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *N/A*

5. Comments / Notes

Charges and payment data were provided by Wittman Enterprises. Cost data was taken from a third-party consultant's 2020 fee study report (The Matrix Group) and isolated to CalOptima transports during the given date range using trip counts from Wittman Enterprises (9.9% or 1,401 out of 14,150 total transports).

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Scott Haberle, Fire Chief

Signature & Date: 6/24/2024

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NEWPORT BEACH FIRE DEPARTMENT

100 CIVIC CENTER DRIVE, P.O. BOX 1768, NEWPORT BEACH, CA 92660
PHONE: 949-644-3355 WEB: www.newportbeachca.gov

JEFF BOYLES
Fire Chief

June 20, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Newport Beach, a governmental entity, federal I.D. Number 956000751 in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Newport Beach is willing to contribute approximately $367,822 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kristin Thompson, EMS Division Chief: 100 Civic Center Drive, Newport Beach, CA 92660, kthompson@nbfd.net, (949)644-3385.

Raymund Reyes, Administrative Manager: 100 Civic Center Drive, Newport Beach, CA 92660, rreyes@nbfd.net, (949)644-3352.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Jeff Boyles
Fire Chief

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Newport Beach
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 705,523.45	$ 667,371.00	$ 134,955.38	$ 570,568.07	$ 532,415.62
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 705,523.45	$ 667,371.00	$ 134,955.38	$ 570,568.07	$ 532,415.62

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? **YES**

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

All services provided to CalOptima members are on an oupatient basis and consist of emergency ambulance transportation services. These services are provided to the residents and visitors of Newport Beach on a non-contracted basis.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Newport Beach operating as the Fire Department

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City/Municipal Corporation

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The source of the IGT funds are estimated to be unrestricted General Fund monies from the City of Newport Beach

(iv) Does the transferring entity have general taxing authority? **YES**

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. **N/A**

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Jeff Boyles, Fire Chief

Signature & Date: [signature]

City of Orange

300 E. Chapman Ave.
Orange, CA 92866

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Orange, a governmental entity, federal I.D. Number 95-60007555, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Orange is willing to contribute approximately $579,294 for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Bryan Johnson, EMS Manager
300 E. Chapman Ave. Orange, CA 92866
bjohnson@cityoforange.org
(714) 288-2503

Nathalia Flores, Administrative Analyst
300 E. Chapman Ave. Orange, CA 92866
nflores@cityoforange.org
(714) 288-2533

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Tom Kisela
City Manager

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	City of Orange
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 1,675,657.22	$ 1,675,657.22	$ 341,620.60	$ 1,334,036.62	$ 1,334,036.62
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 1,675,657.22	$ 1,675,657.22	$ 341,620.60	$ 1,334,036.62	$ 1,334,036.62

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***Yes***

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

911 dispatched emergency treatment and ground ambulance transport

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)
City of Orange's unreserved general fund

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Tom Kisela, City Manager

Signature & Date: [signature] 6/6/24

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VERONICA KELLEY, DSW, LCSW
AGENCY DIRECTOR

JASON AUSTIN, MA, LMFT
ASSISTANT AGENCY DIRECTOR

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

OFFICE OF THE DIRECTOR

June 20, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Attachment A-Letter of Interest for Voluntary Rate Range Program IGT 13

Dear Mr. Bishop:

This letter confirms the interest of County of Orange Health Care Agency, a governmental entity, federal I.D. Number 95-6000928, in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Pending approval by the Orange County Board of Supervisors, the County of Orange Health Care Agency is willing to contribute approximately **$3,547,480** for the Calendar Year 2023 (January 1, 2023 - December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

> Anza Vang
> Assistant Deputy Director, Public Health Services
> Orange County Health Care Agency
> 405 W. 5th Street, 7th Floor, Santa Ana, Ca 92701
> (714) 615-6958

I certify that I am authorized to sign this certification on behalf of the government entity and that the statements in this letter are true and correct.

Thank you for your consideration,

DocuSigned by:
Dr. Kelley
E8B80965A4EC417...

Veronica Kelley
Agency Director

CC: Jenna Sarin, Director of Public Health and Nursing
Anza Vang, Assistant Deputy Director, Public Health Services
Strategic Development, CalOptima Health

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name: Orange County Health Care Agency
County: Orange
Health Plan: CalOptima

Instructions
Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 12,437,811.54	$ 6,007,006.80	$ 32,439.62	$ 12,405,371.92	$ 5,974,567.18
Total	$ 12,437,811.54	$ 6,007,006.80	$ 32,439.62	$ 12,405,371.92	$ 5,974,567.18

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***No***

If **No**, please specify the amount of funding available: $ 3,547,480.00

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

STD Clinic - Testing for sexually transmitted diseases (STD) including HIV. Treatment for STDs and linkage to care for individuals who test HIV-positive. Counseling and Prevention services for STDs and HIV.
TB Clinic - Diagnosis, treatment and case management for Orange County residents with tuberculosis (TB) disease.
Child Health Clinic - Sick child care, conducts developmental screening, and renders limited follow-up services for conditions found on the physical examination.
Medically High Risk Newborn Nursing Services - Public Health Nurse's (PHN) provide comprehensive case management services to medically fragile newborns and infants. A PHN assists parents/caregivers to help promote optimum growth and development in the infant; care for infants with special needs, and develop supportive family dynamic that promote attachment. Nurses provide continuing growth and developmental assessment, parental education and assistance in accessing necessary health services for high-risk infants.
Nurse Family Partnership (NFP) - NFP is an evidenced-based nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Nurse case managers improve the following: pregnancy outcomes, child health and development and economic self-sufficiency of the family.
Perinatal Substance Abuse Nursing Services - Public Health Nurses provide case management services for pregnant persons who have a history of substance use disorder, mental health issues, homelessness, and/or have HIV infection. PHN aide clients in gaining access to necessary health services and pediatric care during the client's pregnancy and through the first 6-12 month of the child's life. Services include, case management, education, coordination of care, and referrals to resources so mothers will have a healthy-drug free delivery and positive development environment for the infant.
Adolescent Family Life Program (ALFP) - Offers comprehensive case management services from social workers and licensed clinicians to expectant and parenting teens up to the age of 21 years and their children. Case managers work closely with youth to improve the health and well-being of themselves and their children providing support and linkage to services such as health services, mental health services, developmental, education, child care, transportation, financial aid, legal services, and parenting classes .

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: County of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County

(iii) The source of the funds: Net County Cost and or Health Realignment
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: Veronica Kelley, Orange County Healthcare Agency Director

Signature & Date: DocuSigned by: Dr. Kelley E8B80965A4EC417... 6/26/2024

UCI Health

June 11, 2024

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services 1501
Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: UCI Health and CalOptima IGT 2023

Dear Mr. Bishop:

This letter confirms the interest of Regents of the University of California Irvine Medical Center, a governmental entity, federal I.D. Number 95-2226406, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Regents of University of California, Irvine Medical Center is willing to contribute approximately 89% of the total available for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Christopher M. Leo, Esq.
Director of Government Affairs
UCI Health
101 City Drive, Bldg. 53, Suite 100
Orange, CA 92868
cmleo@hs.uci.edu
(714) 456-2967

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Chad T. Lefteris, FACHE
President & Chief Executive Officer
UCI Health

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name: University of California, Irvine Health
County: Orange
Health Plan: CalOptima

Instructions
Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient	$ 85,601,286.97	$ 64,157,276.35	$21,444,010.62	$ 64,157,276.35	$ 42,713,265.73
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$87,424,867.91	$ 65,946,999.12	$21,477,868.79	$ 65,946,999.12	$ 44,469,130.33
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 173,026,154.88	$ 130,104,275.47	$ 42,921,879.41	$ 130,104,275.47	$ 87,182,396.06

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***Yes***

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

Yes, services are provided under contract arrangement. Inpatient and outpatient (including emergency services) medical services at UC Irvine Health are provided by UPS physicians. Physician medical specialty care includes those services considered tertiary and quaternary. UPS physician services are made available to CalOptima members through provider agreements between UPS and CalOptima.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: UCI University Physicians & Surgeons (UPS)

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: Governmental Funding Entitiy

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Patient care revenue

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: Chad T. Lefteris, President & Chief Executive Officer

Signature & Date: 6/11/24

Voluntary Rate Range Program
Attachment C
January 1, 2023 - December 31, 2023

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 23 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,472,048	99.09	$ 106.27	$ 7.18	$ -	$ 7.18	$ 24,929,305	$ 10,525,551	42.22%
506	CalOptima	Orange	Child	UIS	148,873	32.09	$ 34.73	$ 2.64	$ -	$ 2.64	$ 393,025	$ 177,141	45.07%
506	CalOptima	Orange	Adult	SIS	1,423,569	212.50	$ 225.70	$ 13.20	$ -	$ 13.20	$ 18,791,110	$ 8,573,220	45.62%
506	CalOptima	Orange	Adult	UIS	267,683	178.51	$ 189.06	$ 10.55	$ -	$ 10.55	$ 2,824,056	$ 1,254,778	44.43%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,773,376	304.58	$ 322.43	$ 17.85	$ 4.46	$ 13.39	$ 50,525,505	$ 5,052,550	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	419,435	292.09	$ 308.77	$ 16.68	$ 4.17	$ 12.51	$ 5,247,132	$ 575,180	10.96%
506	CalOptima	Orange	SPD	SIS	442,469	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 20,397,821	$ 9,515,885	46.65%
506	CalOptima	Orange	SPD	UIS	86,182	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 3,595,513	$ 1,661,790	46.22%
506	CalOptima	Orange	SPD/Full-Dual	SIS	1,299,679	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 20,807,861	$ 9,720,739	46.72%
506	CalOptima	Orange	SPD/Full-Dual	UIS	6,355	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 44,104	$ 20,604	46.72%
506	CalOptima	Orange	LTC	SIS	2,597	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 119,722	$ 55,930	46.72%
506	CalOptima	Orange	LTC	UIS	1,559	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 65,041	$ 30,381	46.71%
506	CalOptima	Orange	LTC/Full-Dual	SIS	31,893	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 510,607	$ 238,539	46.72%
506	CalOptima	Orange	LTC/Full-Dual	UIS	124	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 861	$ 402	46.69%
506	CalOptima	Orange	Whole Child Model	SIS	133,436	1,761.91	$ 1,852.98	$ 91.07	$ -	$ 91.07	$ 12,152,017	$ 5,094,006	41.92%
506	CalOptima	Orange	Whole Child Model	UIS	4,171	552.77	$ 583.55	$ 30.78	$ -	$ 30.78	$ 128,383	$ 54,716	42.62%
506	**CalOptima**	**Orange**	**All COAs**		**11,513,449**	**287.15**	**$ 302.71**	**$ 15.56**	**$ 8.63**	**$ 13.94**	**$ 160,532,063**	**$ 52,551,412**	**32.74%**

Footnotes:
1 The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 23 MM effective as of March 2024.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar
9. Approve Modifications to CalOptima Health Policy GA.8053: Workplace Violence

Contacts
Nancy Huang, Chief Financial Officer, (657) 235-6935
Donna Guerrero, Director, Facilities, (657) 900-1473

Recommended Action
Approve modifications to CalOptima Health Policy GA.8053: Workplace Violence.

Background
Policy GA.8053 establishes guidelines for responding to workplace violence to minimize the threat toward CalOptima Health's employees. The original policy was created in 2014.

California Senate Bill (SB) 553, Workplace Violence, was signed into law on September 30, 2023, creating the first general-industry safety requirement for workplace violence prevention in the United States. The law requires employers to develop and implement a Workplace Violence Prevention Plan with live training by July 1, 2024.

Discussion
SB 553 requires CalOptima Health to adopt and implement a Workplace Violence Prevention Plan and corresponding live training for its employees by July 1, 2024. The Workplace Prevention Plan must address topics of threats of violence, bullying, harassment, active shooter, hostage situations, and physical security and safety.

Staff have reviewed and updated existing Policy GA.8053: Workplace Violence and added CalOptima Health's Workplace Violence Prevention Plan as an attachment to meet the new California Labor Code requirements as outlined in SB 553.

Staff have also made non-substantive changes that include minor clarifying language, formatting, spelling, and other grammatical changes.

Fiscal Impact
The estimated cost of the required annual live training is $21,000 per year. The CalOptima Health Fiscal Year 2024-25 Operating Budget includes sufficient funding to support the annual training.

Rationale for Recommendation
The recommended action will allow CalOptima Health to be in compliance with requirements of SB 553, Workplace Violence.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Updated CalOptima Health Policy GA.8053: Workplace Violence

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Back to Agenda

Policy:	GA.8053
Title:	**Workplace Violence**
Department:	Facilities
Section:	Environmental Health & Safety
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	07/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

This policy establishes guidelines for responding promptly and effectively to Workplace Violence and to minimize the Threat of violence in the workplace toward CalOptima Health ~~and CalOptima Health PACE~~ Employees ~~who are~~ located on CalOptima Health Property ~~at 505 City Parkway West, Orange, CA 92868 and the CalOptima Health PACE Center at 13300 Garden Grove Blvd., Garden Grove, CA 92843 (hereinafter collectively referred to as "CalOptima Health Property").~~ .

II. POLICY

A. CalOptima Health seeks to provide a safe and healthy work environment for Employees, ~~as required~~ pursuant to ~~CA~~California Labor Code, Section 6400 free from Threats, Intimidation, Harassment, and acts of Workplace Violence. CalOptima Health strives to protect its Employees from unsafe conditions and ensure that CalOptima Health Property is restricted to individuals that are recognized as Employees, vendors, board members, potential candidates, or other appropriate guests, in accordance with Title 8 of the California Code of Regulations, Section 3203.

B. CalOptima Health seeks to provide a work environment that minimizes Workplace Violence, or other security risks~~.~~ through the CalOptima Health Workplace Violence Prevention Plan, as required pursuant to California Labor Code, Section 6401.9.

C. All Employees are responsible for minimizing Workplace Violence and for reporting suspicious activity, any acts of violence, Threats, Harassment, or Intimidation.

D. CalOptima Health shall take appropriate actions, including, but not limited to, Employee discipline up to and including termination, to protect, as fully as possible, all Employees and members of the public from Workplace Violence, which may occur in, or on, CalOptima Health Property and during the performance of CalOptima Health business operations.

E. Except for sworn personnel, Employees are not permitted to bring, or possess, within any CalOptima Health Property, or while engaged in CalOptima Health business, any firearm, explosive, deadly weapon, tear gas weapon, taser, or stun gun, any other item that is primarily used as a weapon, or any instrument that expels a metallic projectile, such as a BB, or pellet, through the force of air pressure, CO_2 pressure, or spring action, or any spot marker gun, or paint gun.

F. CalOptima Health's Environmental Health and Safety ~~Manager,~~Department or ~~his or her~~ their Designee, shall be the point of contact for investigating, conducting, and submitting Workplace Violence reports to the police department, where applicable, and shall retain a copy of the report.

G. This policy does not replace or affect CalOptima Health's procedures as described in CalOptima Health Policies, GA.8016: Unusual Occurrence, GA.8027: Harassment, Discrimination, and Retaliation Prevention, and GG.1317: Response to Disruptive and Threatening Behavior by Members~~, GA.8016: Unusual Occurrence, and GA.8027: Unlawful Harassment~~ .

III. PROCEDURE

A. Training

1. On an annual basis, the Director of Facilities and Environmental Health and Safety ~~Manager,~~ and the Training & Education team in the Human Resources Department shall provide training ~~programs~~on the CalOptima Health Workplace Violence Prevention Plan , and as necessary, inform Employees of methods and procedures to identify, minimize, report, and respond to unsafe conditions, Workplace Violence, Threats, Harassment, Intimidation, and/or acts of violence such as an active gunman, whether perpetrated by a coworker, or by a third party.

B. Facility Risk Assessment (FRA)

1. On an annual basis, CalOptima Health shall conduct and maintain ~~an~~an FRA of the risks of Workplace Violence and/or other security risks that exist as a result of the nature of the work and physical environment of the organization, in accordance with Occupational Safety and Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Health Care and Social Workers, OSHA 3148--06R (2016).

2. The FRA must be approved by the Executive Staff.

3. The FRA shall be conducted by the Environmental Health and Safety ~~Manager~~Department, and may include, but not be limited to, the following:

   a. CalOptima Health's Director of Facilities; and

   b. The CalOptima Health Safety Committee

4. The Environmental Health and Safety ~~Manager~~Department shall develop guidelines for the FRA and shall consult with departments, if requested to do so.

5. At the conclusion of the FRA, each department affected shall complete a written report and submit it to the Executive Staff for review.

6. The Executive Staff may review and revise the FRA report or return it to the Environmental Health and Safety ~~Manager~~Department or Director of Facilities for further review.

7. The FRA report may include recommendations, including, but not limited to, the following:

   a. Budgeted funds availability;

   b. Recommendation to alter the physical environment to make it more secure from potential violent acts; and

   c. Appropriate level of public access to the department's Employees and facilities.

For 20240801 BOD Review Only

8. Copies of the FRA report shall be kept by CalOptima Health's Environmental Health and Safety ~~Manager~~Department.

9. On an annual basis, the Environmental Health and Safety ~~Manager~~Department, and Director of Facilities shall be responsible for reviewing the FRA report for the following circumstances, including, but not limited to:

   a. When the physical environment at CalOptima Health, or CalOptima Health PACE Center changes;

   b. The nature of the work performed by the various departments at CalOptima Health, or the CalOptima Health PACE Center changes; and

   c. Other times, as determined by the Director of Facilities, and Environmental Health and Safety ~~Manager~~Department.

C. The Environmental Health and Safety ~~Manager~~Department shall provide each department at CalOptima Health, or the CalOptima Health PACE Center, with generic departmental procedures, written templates, and training for minimizing and effectively responding to Workplace Violence.

D. CalOptima Health's departments, or the CalOptima Health PACE Center, may modify the generic departmental procedures to meet its unique circumstances.

E. CalOptima Health or the CalOptima Health PACE Center will respond to emergencies involving sudden, unexpected occurrences that pose a clear and imminent danger requiring immediate action to prevent, or mitigate, the loss or impairment of life, health, or property as outlined in CalOptima Health Policy GA.8016: Unusual Occurrence. CalOptima Health or the CalOptima Health PACE Center shall provide a prompt report of Workplace Violence to CalOptima Health's Environmental Health and Safety ~~Manager~~Department~~.~~, which may be reported to the police department and to anyone affected by Workplace Violence.

F. Departmental procedures shall consist of, but are not limited to, the following:

   1. Guidelines to supervisors/managers on how to respond to Employees whose work performance, or safety, is affected by Workplace Violence; and

   2. On-going measures to minimize and respond to Workplace Violence that occurs away from CalOptima Health, or the CalOptima Health PACE Center, property for those departments that have Employees who regularly perform duties away from CalOptima Health Property.

G. The Environmental Health and Safety ~~Manager~~Department and Director of Facilities shall assist CalOptima Health departments and the CalOptima Health PACE Center in developing departmental procedures.

H. CalOptima Health's individual departmental procedures must be approved by the Director of Facilities, Environmental Health and Safety ~~Manager~~Department, and the Executive Staff.

I. Copies of CalOptima Health's individual departmental procedures shall be kept in the respective department~~ and in~~, the Environmental Health and Safety ~~Manager, and~~Department, the Director of Facilities offices and shall be distributed to departmental Employees.

J. Employee's Responsibility for Responding to and Reporting Workplace Violence:

For 20240801 BOD Review Only

1. Employees shall respond promptly to Workplace Violence in accordance with their individual department procedures as described in the CalOptima Health Workplace Violence Prevention Plan.

2. Supervisors/managers shall respond promptly to Workplace Violence, in accordance with their individual department procedures and shall orally report Workplace Violence to the Environmental Health and Safety ~~Manager~~Department, or Director of Facilities, or his or her Designee, as soon as possible.

3. In emergency situations, Employees may report Workplace Violence to supervisory, or managerial, level Employees other than their own supervisors.

4. Employees shall promptly report situations to their supervisors that they believe could lead to Workplace Violence, including, but not limited to, protective orders, restraining orders, or other "no-contact" orders.

5. An Employee who is a victim of domestic violence, sexual assault, or stalking and who requests an accommodation, subject to the requirements of Labor Code, Section 230, for the safety of the Employee while at work shall make such a request to his or her supervisor, where appropriate, or otherwise make a request directly to the Human Resources Department.

K. Responsibilities of Management

1. Managers and supervisors shall ensure that behaviors and actions that may, or are likely to, result in Workplace Violence are dealt with promptly, firmly, and fairly.

2. Disciplinary actions for violations shall be consistent with CalOptima Health policies and procedures.

3. Subject to the requirements under Labor Code, Section 230, managers, Human Resources, and/or the Director of Facilities shall provide reasonable accommodations for an Employee who is a victim of domestic violence, sexual assault, or stalking and who requests an accommodation for the safety of the Employee while at work. However, nothing herein requires CalOptima Health to undertake an action that constitutes an undue hardship on CalOptima Health's business operations.

4. CalOptima Health does not tolerate acts and behaviors that may or are likely to result in Workplace Violence and which may include, but are not limited to, the following:

   a. Verbal abuse such as outbursts, swearing, cursing, or any other abusive language;

   b. Physical violence, direct or indirect, including, but not limited to, hitting, shoving, or throwing objects;

   c. Verbal and nonverbal Threats of bodily harm or property destruction, whether in jest or not;

   d. Threats, or violence, arising out of Harassment based on a protected class as defined in California Civil Code, Section 51, and as further described in CalOptima Health Policy GA.8027: ~~Unlawful Harassment~~Harassment, Discrimination, and Retaliation Prevention, and the CalOptima Health Workplace Violence Prevention Plan;

   e. Brandishing of an object which may be used, or could be perceived as, a weapon;

   f. Insubordination;

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g. The sending of Threatening, Harassing, or Intimidating email, mail, electronic messages (instant messenger, phone text, or social media), and/or facsimile;

h. Using the workplace to violate protective orders; and

i. Stalking.

M. Any Employee, who Threatens, Harasses, Intimidates, or engages in any Workplace Violence, and/or possesses a firearm or firearms and/or any other weapon(s) on CalOptima Health Property, or while conducting CalOptima Health business, except sworn personnel, shall be immediately escorted off CalOptima Health Property, and shall remain off CalOptima Health Property pending the outcome of an investigation. CalOptima Health's response may include disciplinary action, up to and including termination of employment, or criminal prosecution.

N. Each Employee is expected and encouraged to report to any supervisor, or manager, any incident which may be Threatening to them, or their co-workers, or any event which he or she reasonably believes is Threatening, or violent.

O. In the event of a credible Threat of violence, ~~the Legal Affairs Department~~legal counsel shall be contacted immediately, but no later than twenty-four (24) hours after such Threat, in order to promptly obtain all necessary protective orders and/or local law enforcement assistance.

IV. ATTACHMENT(S)

A. CalOptima Health Workplace Violence Prevention Plan (WVPP)
B. CalOptima Health Emergency Response Plan
C. Workplace Active Shooter Response and Prevention

V. REFERENCE(S)

A. California Civil Code, §51
B. California Labor Code, §§230, 6400, 6401.7, and 6401.~~7~~9
C. CalOptima Health Employee Handbook
~~D. CalOptima's Injury and Illness Prevention Program (IIPP)~~
~~E.~~D. CalOptima Health Policy GA.8016: Unusual Occurrence
~~F.~~E. CalOptima Health Policy GA.8027: ~~Unlawful~~ Harassment, Discrimination, and Retaliation Prevention
F. ~~CalOptima~~CalOptima Health Policy GA.8054: Injury and Illness Prevention Program
G. CalOptima Health Policy GG.1317: Response to Disruptive and Threatening Behavior by Members
H. Occupational Safety and Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Health Care and Social Workers, OSHA 3148-06R (2016)
I. Title 8, California Code of Regulations (C.C.R.), §3203
J. Workplace Violence Awareness Presentation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

02/02/2017	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8053	Workplace Violence	Administrative
Revised	02/02/2017	GA.8053	Workplace Violence	Administrative
Revised	10/01/2017	GA.8053	Workplace Violence	Administrative
Revised	08/01/2018	GA.8053	Workplace Violence	Administrative
Revised	01/01/2019	GA.8053	Workplace Violence	Administrative
Revised	01/01/2020	GA.8053	Workplace Violence	Administrative
Revised	04/01/2021	GA.8053	Workplace Violence	Administrative
Revised	10/01/2023	GA.8053	Workplace Violence	Administrative
Revised	07/01/2024	GA.8053	Workplace Violence	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2

Term	Definition
CalOptima Health Property	Any property owned, operated or leased by CalOptima Health, including CalOptima Health owned or leased vehicles, the administration building at 500 and 505 City Parkway West, in the City of Orange, State of California, the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and the CalOptima satellite office located at the County Community Service Center, 15496 Magnolia Street, Suite 111, in the City of Westminster, State of California. CalOptima Health Property shall include surrounding ground and parking lots or spaces owned, operated, ~~or~~ leased or rented by CalOptima Health~~, as well as other leased or rented spaces~~.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Employee	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health Employees, all temporary Employees, interns/volunteers, CalOptima Health Board Members, advisory and Standing Committee Members and authorized contractors and consultants.
Executive Staff	Any CalOptima Health employee whose position title is Executive Director or Chief Officer of one (1) or more departments.
Harassment	Unwelcome conduct or comments, based on a protected characteristic, that are so severe or pervasive as to create an abusive working environment.
Intimidation	The intent to make a person afraid, frightened of, alarmed or scared, or the act of inducing fear by Threats.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.
Threat	A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes Threats made in jest or as a joke, but which others could perceive as serious.
Workplace Violence	Any intentional act that inflicts, attempts to inflict, or Threatens to inflict bodily injury on another person or that inflicts, attempts to inflict, or Threatens to inflict damage to property, whether committed by a CalOptima Health Employee or by anyone else, and which occurs in the workplace, in or on CalOptima Health Property, or while an Employee is engaged in CalOptima Health business.

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Policy:	GA.8053
Title:	**Workplace Violence**
Department:	Facilities
Section:	Environmental Health & Safety
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	07/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

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I. PURPOSE

This policy establishes guidelines for responding promptly and effectively to Workplace Violence and to minimize the Threat of violence in the workplace toward CalOptima Health Employees located on CalOptima Health Property.

II. POLICY

A. CalOptima Health seeks to provide a safe and healthy work environment for Employees, pursuant to California Labor Code, Section 6400 free from Threats, Intimidation, Harassment, and acts of Workplace Violence. CalOptima Health strives to protect its Employees from unsafe conditions and ensure that CalOptima Health Property is restricted to individuals that are recognized as Employees, vendors, board members, potential candidates, or other appropriate guests, in accordance with Title 8 of the California Code of Regulations, Section 3203.

B. CalOptima Health seeks to provide a work environment that minimizes Workplace Violence, or other security risks through the CalOptima Health Workplace Violence Prevention Plan, as required pursuant to California Labor Code, Section 6401.9.

C. All Employees are responsible for minimizing Workplace Violence and for reporting suspicious activity, any acts of violence, Threats, Harassment, or Intimidation.

D. CalOptima Health shall take appropriate actions, including, but not limited to, Employee discipline up to and including termination, to protect, as fully as possible, all Employees and members of the public from Workplace Violence, which may occur in, or on, CalOptima Health Property and during the performance of CalOptima Health business operations.

E. Except for sworn personnel, Employees are not permitted to bring, or possess, within any CalOptima Health Property, or while engaged in CalOptima Health business, any firearm, explosive, deadly weapon, tear gas weapon, taser, or stun gun, any other item that is primarily used as a weapon, or any instrument that expels a metallic projectile, such as a BB, or pellet, through the force of air pressure, CO_2 pressure, or spring action, or any spot marker gun, or paint gun.

F. CalOptima Health's Environmental Health and Safety Department or their Designee, shall be the point of contact for investigating, conducting, and submitting Workplace Violence reports to the police department, where applicable, and shall retain a copy of the report.

G. This policy does not replace or affect CalOptima Health's procedures as described in CalOptima Health Policies, GA.8016: Unusual Occurrence, GA.8027: Harassment, Discrimination, and Retaliation Prevention, and GG.1317: Response to Disruptive and Threatening Behavior by Members.

III. PROCEDURE

A. Training

1. On an annual basis, the Director of Facilities and Environmental Health and Safety, and the Training & Education team in the Human Resources Department shall provide training on the CalOptima Health Workplace Violence Prevention Plan , and as necessary, inform Employees of methods and procedures to identify, minimize, report, and respond to unsafe conditions, Workplace Violence, Threats, Harassment, Intimidation, and/or acts of violence such as an active gunman, whether perpetrated by a coworker, or by a third party.

B. Facility Risk Assessment (FRA)

1. On an annual basis, CalOptima Health shall conduct and maintain an FRA of the risks of Workplace Violence and/or other security risks that exist as a result of the nature of the work and physical environment of the organization, in accordance with Occupational Safety and Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Health Care and Social Workers, OSHA 3148--06R (2016).

2. The FRA must be approved by the Executive Staff.

3. The FRA shall be conducted by the Environmental Health and Safety Department, and may include, but not be limited to, the following:

   a. CalOptima Health's Director of Facilities; and

   b. The CalOptima Health Safety Committee

4. The Environmental Health and Safety Department shall develop guidelines for the FRA and shall consult with departments, if requested to do so.

5. At the conclusion of the FRA, each department affected shall complete a written report and submit it to the Executive Staff for review.

6. The Executive Staff may review and revise the FRA report or return it to the Environmental Health and Safety Department or Director of Facilities for further review.

7. The FRA report may include recommendations, including, but not limited to, the following:

   a. Budgeted funds availability;

   b. Recommendation to alter the physical environment to make it more secure from potential violent acts; and

   c. Appropriate level of public access to the department's Employees and facilities.

8. Copies of the FRA report shall be kept by CalOptima Health's Environmental Health and Safety Department.

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9. On an annual basis, the Environmental Health and Safety Department, and Director of Facilities shall be responsible for reviewing the FRA report for the following circumstances, including, but not limited to:

    a. When the physical environment at CalOptima Health, or CalOptima Health PACE Center changes;

    b. The nature of the work performed by the various departments at CalOptima Health, or the CalOptima Health PACE Center changes; and

    c. Other times, as determined by the Director of Facilities, and Environmental Health and Safety Department.

C. The Environmental Health and Safety Department shall provide each department at CalOptima Health, or the CalOptima Health PACE Center, with generic departmental procedures, written templates, and training for minimizing and effectively responding to Workplace Violence.

D. CalOptima Health's departments, or the CalOptima Health PACE Center, may modify the generic departmental procedures to meet its unique circumstances.

E. CalOptima Health or the CalOptima Health PACE Center will respond to emergencies involving sudden, unexpected occurrences that pose a clear and imminent danger requiring immediate action to prevent, or mitigate, the loss or impairment of life, health, or property as outlined in CalOptima Health Policy GA.8016: Unusual Occurrence. CalOptima Health or the CalOptima Health PACE Center shall provide a prompt report of Workplace Violence to CalOptima Health's Environmental Health and Safety Department, which may be reported to the police department and to anyone affected by Workplace Violence.

F. Departmental procedures shall consist of, but are not limited to, the following:

    1. Guidelines to supervisors/managers on how to respond to Employees whose work performance, or safety, is affected by Workplace Violence; and

    2. On-going measures to minimize and respond to Workplace Violence that occurs away from CalOptima Health, or the CalOptima Health PACE Center, property for those departments that have Employees who regularly perform duties away from CalOptima Health Property.

G. The Environmental Health and Safety Department and Director of Facilities shall assist CalOptima Health departments and the CalOptima Health PACE Center in developing departmental procedures.

H. CalOptima Health's individual departmental procedures must be approved by the Director of Facilities, Environmental Health and Safety Department, and the Executive Staff.

I. Copies of CalOptima Health's individual departmental procedures shall be kept in the respective department, the Environmental Health and Safety Department, the Director of Facilities offices and shall be distributed to departmental Employees.

J. Employee's Responsibility for Responding to and Reporting Workplace Violence:

    1. Employees shall respond promptly to Workplace Violence in accordance with their individual department procedures as described in the CalOptima Health Workplace Violence Prevention Plan.

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2. Supervisors/managers shall respond promptly to Workplace Violence, in accordance with their individual department procedures and shall orally report Workplace Violence to the Environmental Health and Safety Department, or Director of Facilities, or his or her Designee, as soon as possible.

3. In emergency situations, Employees may report Workplace Violence to supervisory, or managerial, level Employees other than their own supervisors.

4. Employees shall promptly report situations to their supervisors that they believe could lead to Workplace Violence, including, but not limited to, protective orders, restraining orders, or other "no-contact" orders.

5. An Employee who is a victim of domestic violence, sexual assault, or stalking and who requests an accommodation, subject to the requirements of Labor Code, Section 230, for the safety of the Employee while at work shall make such a request to his or her supervisor, where appropriate, or otherwise make a request directly to the Human Resources Department.

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1. Managers and supervisors shall ensure that behaviors and actions that may, or are likely to, result in Workplace Violence are dealt with promptly, firmly, and fairly.

2. Disciplinary actions for violations shall be consistent with CalOptima Health policies and procedures.

3. Subject to the requirements under Labor Code, Section 230, managers, Human Resources, and/or the Director of Facilities shall provide reasonable accommodations for an Employee who is a victim of domestic violence, sexual assault, or stalking and who requests an accommodation for the safety of the Employee while at work. However, nothing herein requires CalOptima Health to undertake an action that constitutes an undue hardship on CalOptima Health's business operations.

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   a. Verbal abuse such as outbursts, swearing, cursing, or any other abusive language;

   b. Physical violence, direct or indirect, including, but not limited to, hitting, shoving, or throwing objects;

   c. Verbal and nonverbal Threats of bodily harm or property destruction, whether in jest or not;

   d. Threats, or violence, arising out of Harassment based on a protected class as defined in California Civil Code, Section 51, and as further described in CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention, and the CalOptima Health Workplace Violence Prevention Plan;

   e. Brandishing of an object which may be used, or could be perceived as, a weapon;

   f. Insubordination;

   g. The sending of Threatening, Harassing, or Intimidating email, mail, electronic messages (instant messenger, phone text, or social media), and/or facsimile;

For 20240801 BOD Review Only

h. Using the workplace to violate protective orders; and

i. Stalking.

M. Any Employee, who Threatens, Harasses, Intimidates, or engages in any Workplace Violence, and/or possesses a firearm or firearms and/or any other weapon(s) on CalOptima Health Property, or while conducting CalOptima Health business, except sworn personnel, shall be immediately escorted off CalOptima Health Property, and shall remain off CalOptima Health Property pending the outcome of an investigation. CalOptima Health's response may include disciplinary action, up to and including termination of employment, or criminal prosecution.

N. Each Employee is expected and encouraged to report to any supervisor, or manager, any incident which may be Threatening to them, or their co-workers, or any event which he or she reasonably believes is Threatening, or violent.

O. In the event of a credible Threat of violence, legal counsel shall be contacted immediately, but no later than twenty-four (24) hours after such Threat, in order to promptly obtain all necessary protective orders and/or local law enforcement assistance.

IV. ATTACHMENT(S)

A. CalOptima Health Workplace Violence Prevention Plan (WVPP)
B. CalOptima Health Emergency Response Plan
C. Workplace Active Shooter Response and Prevention

V. REFERENCE(S)

A. California Civil Code, §51
B. California Labor Code, §§230, 6400, 6401.7, and 6401.9
C. CalOptima Health Employee Handbook
D. CalOptima Health Policy GA.8016: Unusual Occurrence
E. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention
F. CalOptima Health Policy GA.8054: Injury and Illness Prevention Program
G. CalOptima Health Policy GG.1317: Response to Disruptive and Threatening Behavior by Members
H. Occupational Safety and Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Health Care and Social Workers, OSHA 3148-06R (2016)
I. Title 8, California Code of Regulations (C.C.R.), §3203
J. Workplace Violence Awareness Presentation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8053	Workplace Violence	Administrative
Revised	02/02/2017	GA.8053	Workplace Violence	Administrative
Revised	10/01/2017	GA.8053	Workplace Violence	Administrative
Revised	08/01/2018	GA.8053	Workplace Violence	Administrative
Revised	01/01/2019	GA.8053	Workplace Violence	Administrative
Revised	01/01/2020	GA.8053	Workplace Violence	Administrative
Revised	04/01/2021	GA.8053	Workplace Violence	Administrative
Revised	10/01/2023	GA.8053	Workplace Violence	Administrative
Revised	07/01/2024	GA.8053	Workplace Violence	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2

Term	Definition
CalOptima Health Property	Any property owned, operated or leased by CalOptima Health, including CalOptima Health owned or leased vehicles, the administration building at 500 and 505 City Parkway West, in the City of Orange, State of California, the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and the CalOptima satellite office located at the County Community Service Center, 15496 Magnolia Street, Suite 111, in the City of Westminster, State of California. CalOptima Health Property shall include surrounding ground and parking lots or spaces owned, operated, leased or rented by CalOptima Health.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Employee	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health Employees, all temporary Employees, interns/volunteers, CalOptima Health Board Members, advisory and Standing Committee Members and authorized contractors and consultants.
Executive Staff	Any CalOptima Health employee whose position title is Executive Director or Chief Officer of one (1) or more departments.
Harassment	Unwelcome conduct or comments, based on a protected characteristic, that are so severe or pervasive as to create an abusive working environment.
Intimidation	The intent to make a person afraid, frightened of, alarmed or scared, or the act of inducing fear by Threats.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.
Threat	A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes Threats made in jest or as a joke, but which others could perceive as serious.
Workplace Violence	Any intentional act that inflicts, attempts to inflict, or Threatens to inflict bodily injury on another person or that inflicts, attempts to inflict, or Threatens to inflict damage to property, whether committed by a CalOptima Health Employee or by anyone else, and which occurs in the workplace, in or on CalOptima Health Property, or while an Employee is engaged in CalOptima Health business.

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For 20240801 BOD Preview Only

CALOPTIMA HEALTH
WORKPLACE VIOLENCE PREVENTION PLAN
Effective: July 1, 2024

PURPOSE

The purpose of the Workplace Violence Prevention Plan (or "WVPP") is to have an effective, clear, accessible, and actionable plan to prevent and respond to workplace violence (as defined below) and workplace violence hazards.

The Workplace Violence Prevention Plan establishes guidelines for responding promptly and effectively to workplace violence and to minimize the threat of violence in the workplace toward CalOptima Health and CalOptima Health PACE Employees who are located on CalOptima Health worksites, including 500, 505 City Parkway West, Orange, CA 92868, and the CalOptima Health PACE Center at 13300 Garden Grove Blvd., Garden Grove, CA 92843.

The WVPP complements the existing CalOptima Health's GA.8053 Workplace Violence policy by laying out more specifically the steps to identify, report, track, and investigate violent incidents to reduce the likelihood of re-occurrence.

California Labor Code section 6401.9 requires California employers to have a plan in place to address the rising prevalence of violence occurring at the workplace. California Labor Code section 6401.9 imposes multiple requirements of an employer which can be broadly grouped into two categories: pre-violent incident activities and post-violent incident activities. The details of both categories are presented in greater detail in the following WVPP.

CalOptima Health will coordinate implementation of the WVPP with other employers, when applicable, to ensure that those employers and employees understand their respective roles, as provided in the WVPP.

GOAL OF THE WORKPLACE VIOLENCE PREVENTION PLAN

The goal at CalOptima Health is to establish a Workplace Violence Prevention Plan to reduce violent incidents in the workplace.

CalOptima Health is committed to employees' safety and health.

CalOptima Health does not tolerate any form of violence in the workplace.

CalOptima Health will promote workplace violence prevention through improved employee awareness, violent incident identification and reporting, tracking of violent incidents, and corrective actions when hazards are recognized.

All managers, supervisors and employees are responsible for implementing and maintaining CalOptima Health's Workplace Violence Prevention Plan. CalOptima Health:

- Encourages employees to participate and help implement the WVPP.
- Requires prompt and accurate reporting of all violent incidents whether or not physical injury has occurred.
- Will not discriminate against victims of workplace violence.

CalOptima Health's expects all employees, including supervisors and managers, to adhere to work practices that are designed to make the workplace more secure, and not to engage in verbal threats or physical actions which create a security or safety threat for others in the workplace.

All CalOptima Health employees, including managers and supervisors, are responsible and accountable for using safe work practices, and for following all policies and procedures, and for assisting in maintaining a safe and secure work environment.

Management at CalOptima Health are responsible for clearly communicating all safety and health policies and procedures involving workplace safety to all employees. Managers and supervisors are expected to enforce the rules fairly and equally.

The WVPP is in effect at all times and at all covered worksites until repealed or rescinded. Employees who are teleworking from a location of the employee's choice, which is not under the control of CalOptima Health are exempt from this WVPP while performing such telework.

The WVPP will be reviewed and updated annually, when a deficiency is observed or becomes apparent, and after a Workplace Violence incident.

WORKPLACE VIOLENCE DEFINITIONS

Emergency - Unanticipated circumstances that can be life threatening or pose a risk of significant injuries to employees or other persons.

Engineering controls - An aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the employee and the hazard.

Log - The violent incident log required by Labor Code section 6401.9.

Plan or WVPP - The workplace violence prevention plan required by Labor Code section 6401.9.

Serious injury or illness - Any injury or illness occurring in a place of employment or in connection with any employment that requires inpatient hospitalization for other than medical observation or diagnostic testing, or in which an employee suffers an amputation, the loss of an eye, or any serious degree of permanent disfigurement, but does not include any injury or illness or death caused by an accident on a public street or highway, unless the accident occurred in a construction zone.

Threat of violence - Any verbal or written statement, including, but not limited to, texts, electronic messages, social media messages, or other online posts, or any behavioral or physical conduct, that conveys an intent, or that is reasonably perceived to convey an intent, to cause physical harm or to place someone in fear of physical harm, and that serves no legitimate purpose.

Workplace violence - Any act of violence or threat of violence that occurs in a place of employment.

Workplace violence includes, but is not limited to, the following:

- The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
- An incident involving a threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.
- The following four workplace violence types:

  Type 1 violence - Workplace violence committed by a person who has no legitimate business at the worksite and includes violent acts by anyone who enters the workplace or approaches employees with the intent to commit a crime.

  Type 2 violence - Workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors.

  Type 3 violence - Workplace violence against an employee by a present or former employee, supervisor, or manager.

  Type 4 violence - Workplace violence committed in the workplace by a person who does not work there but has or is known to have had a personal relationship with an employee.

Workplace violence does not include lawful acts of self-defense or defense of others.

Work practice controls - Procedures and rules which are used to effectively reduce workplace violence hazards.

A. WORKPLACE VIOLENCE PREVENTION PLAN (WVPP)

Completed on: 07/01/2024

B. RESPONSIBILITIES

1. Plan Administrator

The Director of Facilities and Environmental Health & Safety Donna Guerrero, has the authority and responsibility for implementing the provisions of this WVPP for CalOptima Health.

The WVPP will be developed in cooperation with the related departments such as Environmental Health & Safety (or "EH&S"), Facilities, and Human Resources (or "HR").

The EH&S department is responsible for investigating each incident, conducting post-incident investigations and corrective actions, documenting the incidents and findings in the corresponding attachments, and updating the corrective actions to the WVPP.

2. Departmental Support

The Facilities and Environmental Health & Safety departments and individuals who are responsible for supporting, implementing, and maintaining the WVPP are listed below:

Responsible Persons	Job Title/Position	Phone #	Email
Donna Guerrero	The Director of Facilities and Environmental Health & Safety	657-900-1473	donna.guerrero@caloptima.org
Cesar Martinez	EH&S Project Manager I	657-235-6882	cesar.martinez@caloptima.org

The responsible persons will perform, or coordinate the performance of, WVPP duties that include, but are not limited to the following:

- Establishing and coordinating Work Practice Controls;
- Establishing and coordinating Engineering Controls;
- Responding to reports of Workplace Violence incidents and Workplace Violence hazards, including investigating incidents of Workplace Violence and Workplace Violence hazards.

3. Safety Committee

Various responsibilities set forth in this WVPP may be performed by the Safety Committee in consultation with the Director of Facilities and Environmental Health & Safety and the EH&S Project Manager I.

4. Managers and Supervisors

All managers and supervisors are responsible for implementing and maintaining the WVPP in their work areas and for answering employee questions about the WVPP. Managers and supervisors who do not know or who are unsure about the answer to a question should direct the employee to the Director of Facilities and Environmental Health & Safety.

As per the Injury and Illness Prevention Program ("IIPP"), managers and supervisors are responsible for promoting a secure work environment for their staff, including the identification of security risks (*i.e.*, workplace violence hazards), staff training needs, the development and management of departmental procedures, and incident reporting, investigation, and follow up.

Supervisors are responsible for completing the Violent Incident Report (Attachment A) with affected employee(s) before submitting it to the EH&S department for investigation and violent incident log completion.

5. Employees

All CalOptima Health employees should be familiar with the WVPP and its requirements. All employees are responsible for using safe work practices, for following all directives, policies, and procedures, and for assisting CalOptima maintain a safe and secure work environment. All employees are required to know, understand, and adhere to the safety rules that apply to their workplace and the work they perform.

All CalOptima Health employees are responsible for reporting hazards and injury or illness incidents in accordance with

the IIPP, including hazards and incidents related to workplace violence. Employees are also responsible for assisting management and the EH&S department in incident investigations, corrective actions, WVPP annual review, and WVPP updates.

C. ACCESS

The WVPP is available for employee access and review. It can be found posted on the Info net, https://caloptima.sharepoint.com/sites/EnvironmentalHealthandSafety, where employees can also print and email the current version of the WVPP. CalOptima Health also makes the WVPP available to Department of Occupational Safety and Health ("DOSH") representatives upon request.

CalOptima Health will make the WVPP available to an employee's designated representatives if the employee provides written authorization to the Director of Facilities and Environmental Health & Safety that contains the following information:

- The name and signature of the employee authorizing a representative of the employee to access the WVPP on the employee's behalf;
- The date of the request;
- The name of the designated representative (individual or organization) authorized to receive the WVPP on the employee's behalf; and
- The date upon which the Written Authorization will expire, if less than one (1) year.

D. TRAINING, AND COMMUNICATION

1. Training

All employees, including managers and supervisors, will receive workplace violence prevention training consistent with this WVPP and applicable law. The training may consist of presentations, discussions, and/or practical exercises.

Training will be provided as follows:

- When the WVPP is first established.
- Annually to ensure all employees understand and comply with the WVPP.
- Whenever a new or previously unrecognized workplace violence hazard has been identified or changes are made to the WVPP. The additional training may be limited to addressing the new workplace violence hazard or changes to the WVPP.

CalOptima Health will provide its employees with training and instruction on the WVPP, including the above definitions and the requirements of the Plan, as well as the following:

- How to obtain a copy of the Workplace Violence Prevention Plan at no cost.
- How to participate in the development and implementation of the WVPP.
- How to report workplace violence incidents or concerns to CalOptima Health or law enforcement without fear of retaliation.
- Workplace violence hazards at CalOptima Health and corrective measures.
- How to seek assistance to prevent or respond to violence and strategies to avoid bodily harm.
- The Log.
- How to obtain copies of records relating to hazard identification, assessments and corrective actions, training records, and Logs.

2. Departmental Supplemental Training

Departmental-specific training may be provided for supervisors/managers on the incident report (Attachment A), how to complete the report after an incident occurs, and the timelines for completion.

3. Active Involvement

CalOptima Health encourages the active involvement of employees in developing and implementing the WVPP, including

through their (a) participation in identifying, evaluating, and correcting Workplace Violence hazards; (b) designing and implementing training; and (c) reporting and investigating Workplace Violence incidents.

4. Communication

CalOptima will communicate to employees about reporting and investigating Workplace Violence hazards and incidents and will inform employees that they may do so without fear of retaliation.

CalOptima Health will maintain ongoing open communications with employees about safety concerns and will review the WVPP at least annually. Ongoing communications can be met via regularly scheduled meetings, newsletters, emails, or bulletins.

Employees may submit questions and concerns to https://caloptima.sharepoint.com/sites/EnvironmentalHealthandSafety.

E. EMPLOYEE REPORTING OBLIGATIONS

Employees should feel comfortable raising any Workplace Violence incident, Threat of Violence, or other Workplace Violence concern to CalOptima Health or law enforcement without fear of reprisal. Employees who become aware of any Workplace Violence incident, Threat of Violence, or other Workplace Violence concern should make a report as soon as possible through any of the following means:

- Reporting to any manager or supervisor verbally or in writing;
- Reporting to the Director of Facilities and Environmental Health & Safety or the EH&S department;
- Reporting to the HR department; and/or
- Reporting to law enforcement or emergency medical services or calling 9-1-1.

Managers and supervisors who receive reports must inform the EH&S department and the Director of Facilities and Environmental Health & Safety, and otherwise respond promptly to the report in accordance with their individual department procedures, including notifying law enforcement, if applicable.

CalOptima Health Employees reporting obligations include reporting as set forth above any situations they believe could lead to Workplace Violence, including, but not limited to, protective orders, restraining orders, or other "no-contact" orders.

F. RESPONSE TO WORKPLACE VIOLENCE, THREATS OF VIOLENCE, AND EMERGENCIES

CalOptima Health will accept and respond to all reports and incidents of Workplace Violence, Threats of Violence, and Workplace Violence Emergencies by doing the following, as applicable:

- Alerting employees of the presence, location, and nature of the Workplace Violence emergency by CalOptima Health's mass notification system Everbridge (employees with questions about Everbridge, including enrolling in this system, should contact the Director of Facilities and Environmental Health & Safety or the EH&S department);
- Taking necessary measures to facilitate injured employees receiving prompt medical evaluation and treatment;
- Taking necessary measures to prevent other employees from being injured;
- Taking necessary measures to facilitate injured employees receiving medical care, if such care is not provided on site;
- Immediately reporting to DOSH any Serious Injury or Illness or death of an employee that is attributable to Workplace Violence;
- Investigating reports as provided in the WVPP;
- If an employee has suffered unlawful violence or a credible Threat of Violence from any individual, which may reasonably be carried out at any of CalOptima Health's worksites, CalOptima Health may attempt to obtain a TRO on behalf of the employee; and/or
- Document all work-related injuries or illness caused by Workplace Violence that resulted in death, loss of consciousness, days away from work, restricted work activity or job transfer, or medical treatment beyond first aid to DOSH.

During a Workplace Violence Emergency, employees are encouraged to evacuate, shelter in place, call for help, and/or call 9-1-1, as applicable. CalOptima Health's evacuation and shelter in place protocols are located in the Emergency Response Plan, which is attached at Attachment D, and the Workplace Active Shooter Response and Prevention plan, which is attached

as Attachment E. The Emergency Response Plan and the Workplace Active Shooter Response and Prevention plan are also available here: https://caloptima.sharepoint.com/sites/EnvironmentalHealthandSafety.

G. VIOLENT INCIDENT INVESTIGATION

CalOptima Health will respond to reports of Workplace Violence or a Threat of Violence by promptly initiating an investigation, as applicable. Investigation procedures may include, but are not necessarily limited to, the following:

- A visit to the incident scene as soon as safe and practicable.
- Interviews of threatened or injured workers and witnesses.
- Review Violent Incident Reports (as set forth below).
- Examination of the workplace for factors associated with workplace security, including any previous reports of inappropriate behavior by the perpetrator.
- Determination of the cause of the violent incident.

The EH&S department or designee are required to complete the investigation in a timely manner and use Attachment B.

Following an investigation, CalOptima Health may take the following measures, as applicable:

- Notify the affected employees of the general results of the investigation, while protecting the privacy of affected and/or involved employees;
- Implement changes in Engineering Controls, procedures, or policies, if appropriate;
- Establish updated Work Practice Controls, if necessary; and/or
- Update the WVPP as appropriate and necessary.

H. TEMPORARY RESTRAINING ORDERS AND TIME OFF WORK

CalOptima Health will not take adverse action against any employee who takes time off from work in order to seek a Temporary Restraining Order ("TRO") or to obtain other assistance to help safeguard the "health, safety, or welfare" of the employee or their child based on such conduct. An employee may use paid sick leave or other leave pursuant to applicable CalOptima Health policies to take time off from work for these purposes.

An employee who is a victim of domestic violence, sexual assault, or stalking and who requests an accommodation, subject to the requirements of Labor Code, Section 230, for the safety of the employee while at work shall make such request to his or her supervisor, where appropriate, or otherwise make a request directly to the Human Resources Department.

An employee shall provide CalOptima Health reasonable and advance notice of their intention to take time off from work for either of these purposes if feasible. If advance notice is not feasible, employees must provide a certification to the employer within a reasonable time after the absence.

I. VIOLENT INCIDENT REPORT

The Violent Incident Report (Attachment A) shall be completed by the affected employee's immediate supervisor with the affected employee and submitted to the EH&S department. If the immediate supervisor is not available, the report shall be completed by the next level of management. Supervisors with questions about completing the Violent Incident Report should seek guidance from the EH&S department

The Violent Incident Report should be completed as soon as possible while the details of the event are still fresh in the victim's mind, ideally within twenty-four (24) hours. Creating a culture and environment where an employee is comfortable coming forward to report a violent incident is crucial. If the incident is between an employee and their supervisor, the EH&S department must complete the Violent Incident Report.

J. VIOLENT INCIDENT LOG COMPLETION

The EH&S department will complete the Violent Incident Log (Attachment C) with the details of the Violent Incident Report (Attachment A) and completed Violent Incident Investigation form (Attachment B) and consistent with the directions on the Violent Incident Log.

Information that is recorded in the Log for each incident shall be based on information solicited from the employees who experienced Workplace Violence, on witness statements, and on investigation findings. CalOptima Health will omit from

the Log any element of personal identifying information that would be sufficient to allow identification of any person involved in a Workplace Violence incident, identifying a record number (as shown with an example in Attachment C) instead of employee names allows tracking while protecting confidentiality. The Log and supporting materials should be audit ready.

The Log should be reviewed by EH&S at least annually, or sooner if there are more frequent incidents of Workplace Violence incidents. The Log data must be maintained for a minimum of five (5) years.

K. WORKPLACE VIOLENCE HAZARD IDENTIFICATION

CalOptima Health will:

- Undertake all necessary actions to identify, evaluate, and correct Workplace Violence hazards.
- Undertake all necessary actions to identify Workplace Violence hazards.
- Conduct inspections of its workplace(s) to identify Workplace Violence hazards.

Specifically, CalOptima Health will conduct inspections under the following circumstances:

- When the WVPP is first established;
- After each Workplace Violence incident; and
- Whenever CalOptima Health is made aware of a new or previously unrecognized hazard.

Periodic inspections to identify and evaluate Workplace Violence and hazards will be performed by the Safety Committee.

Inspections for Workplace Violence hazards may include assessing factors specific to CalOptima Health's workplace, such as the following:

- The need for violence surveillance measures, such as cameras;
- Procedures for reporting suspicious persons or activities;
- Effective location and functioning of emergency buttons and alarms;
- Posting of emergency telephone numbers for law enforcement, fire, and medical services;
- Whether employees have access to a telephone with an outside line;
- Whether employees have effective escape routes from the workplace;
- Whether employees have a designated safe area where they can go to in an emergency;
- Adequacy of workplace security systems, such as door locks, entry codes or badge readers;
- Frequency and severity of threatening or hostile situations that may lead to violent acts by persons who are members of CalOptima Health;
- Employees' skill in safely handling threatening or hostile members;
- Effectiveness of systems and procedures that warn others of actual or potential Workplace Violence danger or that summon assistance, e.g., alarms or panic buttons;
- The use of work practices such as the "buddy" system for specified emergency events;
- The availability of employee escape routes;
- How well CalOptima Health's management and employees communicate with each other;
- Access to and freedom of movement within the workplace by non-employees, including recently discharged employees or persons with whom one of our employees is having a dispute;
- Frequency and severity of employees' reports of threats of physical or verbal abuse by managers, supervisors, or other employees; and
- Any prior violent acts, threats of physical violence, verbal abuse, property damage or other signs of strain or pressure in the workplace.

L. WORKPLACE HAZARD INVESTIGATION AND CORRECTION

CalOptima Health will initiate an investigation following the identification of a Workplace Violence hazard in order to evaluate the nature of the hazard. CalOptima Health may undertake the following as part of such investigation, as applicable:

- Collection of statements from witnesses;
- Collection of photographic or video evidence of damage or injuries, where appropriate; and/or
- Consultation with the affected employees and witnesses to identify potential contributing causes.

After identification and investigation of a Workplace Violence hazard, CalOptima Health will inform affected employees of the results of the investigation, while protecting the privacy of affected and/or involved employees and will take appropriate steps to correct the hazard and prevent or control future or potential hazards by implementing appropriate measures. If changes are made to the WVPP or corrective actions taken, these updates or actions will be shared with employees in a timely manner, while protecting the privacy of affected and/or involved employees.

M. COMPLIANCE

All departments at CalOptima Health will ensure that all Workplace Violence policies and procedures are clearly communicated and understood by all CalOptima Health employees. Managers and supervisors will enforce the rules uniformly and consistently. Managers and supervisors who do not enforce the rules and requirements related to the Plan or do not enforce them uniformly and consistently may be subject to discipline, up to and including termination.

Annual completion of training by all CalOptima Health employees is required to help ensure that the best practices for violence prevention are followed.

All employees will follow all Workplace Violence policies and procedures and help in maintaining a safe work environment. Failure to comply with the WVPP and/or the policy prohibiting employee violence in the workplace may result in employee discipline up to and including termination as well as criminal prosecution.

N. PROHIBITION OF RETALIATION

CalOptima Health has implemented the following measures to prevent and prohibit retaliation against those who report Workplace Violence, a Threat of Violence, or hazards related to Workplace Violence, or who participate in the investigation of such incidents or hazards:

- CalOptima Health responds to reports of Workplace Violence, a Threat of Violence, or hazards related to Workplace Violence in a prompt and timely manner;
- CalOptima Health provides employees multiple channels by which to report incidents, hazards, or concerns;
- CalOptima Health admonishes managers and supervisors not to retaliate against any employee who reports Workplace Violence, a Threat of Violence, or hazards related to Workplace Violence, or any employee who participates in the investigation of such incidents or hazards; and
- CalOptima Health trains all employees that retaliation against any employee who reports Workplace Violence, a Threat of Violence, or hazards related to Workplace Violence, or any employee who participates in the investigation of such incidents or hazards is expressly prohibited and that there are consequences, such as discipline, for retaliation against such employees.

CalOptima Health will not take adverse action against any employee who reports Workplace Violence or who participates in any investigation of Workplace Violence based on such conduct.

O. RECORDKEEPING

CalOptima Health shall maintain the following types of records for the following periods:

Type of Record	Maintenance Period
Records of Workplace Violence hazard identification, evaluation, and correction	Minimum of five (5) years
Training records, including training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions	Minimum of one (1) year

Type of Record	Maintenance Period
Violent Incident Logs	Minimum of five (5) years
Records of Workplace Violence incident investigations. These records must not contain medical information.	Minimum of five (5) years

CalOptima Health shall ensure that records of Workplace Violence Incident Investigations do not contain any medical information including any information in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment that includes or contains any element of personal identifying information sufficient to allow identification of the individual.

CalOptima Health shall make all records required by this WVPP available to DOSH upon request for purposes of examination and copying.

CalOptima Health shall make the following records available to employees and their designated representatives, upon request and without cost, for examination and copying within fifteen (15) calendar days of a request:

- Records of Workplace Violence hazard identification, evaluation, and correction;
- Training records; and
- Violent Incident Logs.

P. ANNUAL WVPP REVIEW

CalOptima Health will on an annual basis review the WVPP confirming accessibility to the plan and assessing its effectiveness and overall employee compliance with the processes outlined in the WVPP. This includes updates and new procedures if improvements can be identified that would reduce workplace violent incidents. The whole plan should be reviewed at least annually or more often if there are violent incidents.

Q. EMPLOYER REPORTING RESPONSIBILITIES

As required by California Code of Regulations ("CCR"), Title 8, Section 342(a). Reporting Work-Connected Fatalities and Serious Injuries, Cal Optima Health will immediately report to Cal/OSHA any serious injury or illness (as defined by CCR, Title 8, Section 330(h)), or death (including any due to Workplace Violence) of an employee occurring in a place of employment or in connection with any employment.

"I, Donna Guerrero, Director of Facilities and EH&S of CalOptima Health, hereby authorize and ensure the implementation, and maintenance of this written workplace violence prevention plan and the documents/forms within this written plan. I am committed to promoting a culture of safety and violence prevention at CalOptima Health and believe that these policies and procedures will help us achieve that goal."

Donna Guerrero, Director of Facilities and EH&S

Signature of person authorizing this WVPP______________________________ Date of Signature: ________________

Attachment A – Violent Incident Report

Violent Incident Report Instructions

The supervisor receiving a report of workplace violence must complete this form with as much detail as possible to support an investigation. The original report must be forwarded to the EH&S department. The department must maintain the original form and will forward a completed copy to the HR department.

Employee Information

Reporting Employee:
____

Reporting Employee's Job Title:
____

Affected Employee(s):
____

Affected Employee(s) Job Title(s):
____

Department:
____

Facility Address:
____

Incident Information

Date incident occurred: ________________________________

Time incident occurred: _______________________________

Specific location, address, and detailed description of where incident occurred (*e.g.*, empty hallway, bathroom, parking lot or other area outside the workplace, or other area):
____
____
____
____

Definitions of Violent Incident Types

- **Type I violence:** Workplace violence committed by a person who has no legitimate business at the worksite and includes violent acts by anyone who enters the workplace or approaches workers with the intent to commit a crime.

- **Type II violence:** Workplace violence directed at employees by customers, clients, patients, students, inmates, or

visitors.

- **Type III violence:** Workplace violence against an employee by a present or former employee, supervisor, or manager.

- **Type IV violence:** Workplace violence committed in the workplace by a person who does not work there but has or is known to have had a personal relationship with an employee.

Checklist of Questions to Answer After a Violent Incident

1. **Which type of person threatened or assaulted the employee(s)?**

   Type I: □ Stranger □ Thief/Suspect □ Other Perpetrator

   Type II: □ Client/Customer □ Passenger □ Person in Custody □ Patient □ Visitor

   Type III: □ Current Co-worker □ Former Co-worker □ Supervisor/ Manager

   Type IV: □ Current Spouse or Partner □ Former Spouse or Partner □ Employee's Current/Former Friend

   □ Employee's Relative □ Person with Other Current/Former Personal Relationship with Employee

2. **What type of violent incident occurred (check all that apply)?**

   □ Verbally Harassed □ Verbally Threatened □ Physically Assaulted □ Punched □ Spit Upon

   □ Slapped □ Grabbed □ Pushed □ Choked □ Kicked □ Bitten □ Hair Pulled □ Pulled □ Scratched

   □ Hit with Object □ Threatened with Weapon □ Assaulted/Hit with Weapon □ Animal Attack

   □ Sexual Assault □ Threat of Sexual Assault □ Threat of Physical Force

   □ Other (Describe): ___________________________________

3. **Was a weapon used? □ Yes □ No**

   Describe the incident:

   ____

   ____

   ____

   ____

4. **What were the circumstances at the time of the incident (e.g., including, but not limited to, whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, isolated or alone, unable to get help or assistance, working in a community setting, or working in an unfamiliar or new location)?**

   ____

   ____

   ____

   ____

5. **Was/Were the employee(s) working alone? □ Yes □ No**

   If not, who was/were with the employee(s) who may have witnessed the incident?

   ____

   ____

6. **Were threats made before the incident occurred? □ Yes □ No**

   If yes, was it ever reported to the employee's supervisor or manager that the employee(s) was/were threatened, harassed, or was/were suspicious that the perpetrator may become violent?

   ____

   ____

   ____

7. **Was security and/or law enforcement contacted? □ Yes □ No**

   If yes, please state whether security and/or law enforcement were contacted and describe their response.

   ____

   ____

   ____

8. **Were actions taken to protect employees from a continuing threat or from any other hazards identified as a result of the incident? □ Yes □ No**

   If yes, please describe.

   ____

   ____

   ____

9. **Are you willing to testify against the perpetrator in court to obtain a restraining order?**

   □ Yes □ No

Report Information

Report Completed By: ____

Department/Job Title: ____

Date: ______________ Phone number: ____

Email: ____

Attachment B – Violent Incident Investigation

The EH&S department or Designee will complete the investigation of the violent incident reported. Further investigation and resolution of the incident is expected within seven (7) business days in addition to submitting a copy of the completed investigation to HR.

Incident Investigation to be completed by EH&S or Designee:

What were the main factors that contributed to the incident?

____

____

____

____

Post-Incident Response

Did the employee(s) require medical attention as a result of the incident? □ **Yes** □ **No**

Did the employee(s) miss work as a result of the incident? □ **Yes** □ **No**

Did the employee(s) apply for workers' compensation? □ **Yes** □ **No**

Was security contacted? □ **Yes** □ **No**

Was building facilities contacted? □ **Yes** □ **No**

Was immediate counseling provided to affected employees and witnesses? □ **Yes** □ **No**

Was critical incident debriefing provided to affected employees who desired it? □ **Yes** □ **No**

Was post-trauma counseling provided to affected employees who desired it? □ **Yes** □ **No**

Was counseling provided by a professional counselor to affected employees who desired it? □ **Yes** □ **No**

Has there been follow-up with the employee(s)? □ **Yes** □ **No**

Are there modifications to be made to the WVPP to reflect updated practices? □ **Yes** □ **No**

Investigation completed by: ____

Department/Job Title: ____

Date: ____________ Phone number: ____

Email: ____

Attachment C – Violent Incident Log and Instructions

Every workplace violence incident is reported and recorded in a violent incident log. Any element of personal identifying information sufficient to allow identification of any person involved in a violent incident will NOT be recorded. Such personal identifying information includes the person's name, address, email address, telephone number, social security number, or other information that, alone or in combination with other publicly available information, could reveal the person's identity.

Upon receipt of a report, EH&S will assign a number system for tracking including the date of the report, the Department, the name and job title of the person who completed the log entry and the date the entry was completed. Tracking and trending should include the following information:

- The date, time and location of the incident,
- The workplace violence type(s):
    - **Type I violence:** Workplace violence committed by a person who has no legitimate business at the worksite and includes violent acts by anyone who enters the workplace or approaches workers with the intent to commit a crime.
    - **Type II violence:** Workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors.
    - **Type III violence**: Workplace violence against an employee by a present or former employee, supervisor, or manager.
    - **Type IV violence:** Workplace violence committed in the workplace by a person who does not work there but has or is known to have had a personal relationship with an employee.
- A detailed description of the incident
- A classification of who committed the violence, including whether the perpetrator was a client or member, family or friend of a client or member, stranger with criminal intent, coworker, supervisor or manager, partner or spouse, parent or relative, or other perpetrator;
- A classification of circumstances at the time of the incident, including, but not limited to, whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, isolated or alone, unable to get help or assistance, working in a community setting, or working in an unfamiliar or new location;
- A classification of where the incident occurred, such as in the workplace, parking lot or other area outside the workplace, or other area;
- The type of incident, including, but not limited to, whether it involved any of the following:
    - Physical attack without a weapon, including, but not limited to, biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching, or spitting.
    - Attack with a weapon or object, including, but not limited to, a firearm, knife, or other object.
    - Threat of physical force or threat of the use of a weapon or other object.
    - Sexual assault or threat, including, but not limited to, rape, attempted rape, physical display, or unwanted verbal or physical sexual contact.
    - Animal attack.
    - Other
- The consequences of the incident, including, but not limited to:
    - Whether security or law enforcement was contacted and their response.
    - Actions taken to protect employees from a continuing threat or from any other hazards identified as a result of the incident.

- Information about the person completing the log, including their name, job title, and the date completed.

Incident logs will be forwarded to EH&S on a timely basis.

The Environmental Health & Safety department will review the data at least quarterly and make improvements to prevent further incidents.

Attachment E

Workplace
Active Shooter
Response and Prevention

REVIEW/REVISION HISTORY

Version	Date	Author/Reviewer Name

CalOptima Health
Emergency Response Plan

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Appendix

1. Introduction to and Purpose of the Emergency Response Plan

The safety and security of CalOptima Health staff, employees, agents, members, and visitors on CalOptima Health property are of the utmost importance to CalOptima Health.

This CalOptima Health Emergency Response Plan (ERP) is intended as a reference tool to assist in the response to potential emergencies. These potential emergencies are anticipated based on the business geographic location, worksite layout, business needs and emergency systems. The goal is preservation of life, property, and prevention of injury. In the event of an emergency, please refer to this plan as a guide to familiarize yourself and others with the procedures outlined. By becoming familiar with the guidelines outlined in this plan, you will be better prepared to respond accordingly to most emergencies. By reviewing and comprehending this plan you will also support CalOptima Health's goal of maintaining a safe and healthful work environment for everyone.

This ERP is a subset of the CalOptima Health Business Continuity Plan (BCP), which is designed to assist with the continuity of critical business functions in a post emergency scenario. The ERP also serves as a guide for the floor warden(s) and the emergency response team procedure(s) While not all actions of an emergency can be anticipated, this plan strengthens CalOptima Health and its employees ability to anticipate an emergency response. The following persons should be contacted for additional information and clarification regarding the ERP:

Manager of Environmental Health & Safety
505 City Parkway West
Orange, CA 92868
Office: (714) 796-6185; Cell: (714) 215-1098

Director of Facilities
505 City Parkway West
Orange, CA 92868
Office: (714) 796-6158; Cell: (714) 316-3899

Additionally, the ERP will be reviewed annually or as required by federal, state, or county agencies.

2. Emergency Phone Numbers

Emergency	911
Orange Police Department – Non-Emergency	(714) 744-7444
Fire Department Non-Emergency	(714) 288-2500
CalOptima Health Security	(714) 795-0435
Property Management Office, Including After Hours Building & Facilities Issues	(714) 939-7777
Reception Security Desk	(714) 385-0030

3. Safety in the Workplace

A safe and secure workplace is everyone's job. If you see something, say something. If you spot a potential safety violation, security issue, or something doesn't look right, report it immediately to management.

- **Remember:**
  - Call 911 in an emergency. If possible, always call 911 from a CalOptima Health soft phone or desk phone. This way, Facilities will be notified and begin their emergency response protocol. If you call from a cell phone Facilities will not be notified, therefore they will not be aware of the emergency and cannot respond.
  - NOTE: If a 911 is misdialed do not panic and hang up, please stay on the line, and inform the operator that it was a misdial. Report unsafe and/or suspicious activity to Facilities, Environmental Health & Safety (EH&S) or Security.

    - Director of Facilities: Gary Thomas (714) 796-6158
    - Environmental Health & Safety Manager: Dan Greene (714) 796-6185
    - CalOptima Health Security (714) 795-0435

  - Your badge must always be visible.
  - Do not loan your badge to anyone.
  - If you lose your badge, report it to Facilities immediately.
  - Do not allow "tail gating" through secure entry doors.
  - Do not let someone in if you cannot see their CalOptima Health badge.
  - Escort visitors out of the building and collect their visitor's badge.
  - Be aware of your surroundings using situational awareness.
  - Vendors are REQUIRED to sign in and out and must return temporary badges to the mail room.
  - All temporary badges are disabled daily at 5 p.m.
  - Restricted passenger elevator access from 5:30 p.m. – 6 a.m., Mon -Fri and weekends.
  - Freight elevator has restricted access 24/7.
  - All visitors must sign in at the Customer Service Reception desk, receive and wear a visitor sticker, AND must sign out at the reception desk.
  - All visitors must wear their visitor badge while in the building.

- All visitors must be escorted by a CalOptima Health representative when in the building.
- The building provides on-site security guard service from 6 a.m. Monday through 6 a.m. Saturday. Drive-by patrol is also provided nightly from 10:00 p.m. until 6:00 a.m., seven (7) nights a week.
    - Two security guards are stationed on the ground floor lobby from 8 a.m. – 5 p.m., Monday – Friday; and One from 5 p.m. until 6 a.m. Monday - Saturday
    - One security guard is stationed in the Customer Service lobby from 8 a.m. – 5 p.m., Monday – Friday.
- Security guards are available to escort you to your car upon your request.
    - A guard is required to patrol the parking lot for a minimum of 15 minutes every hour from 8 a.m. – 5 p.m., Monday - Friday.

- **Situational Awareness**

  Situational awareness is the on-going practice of staying alert and being aware of what is happening in the environment. Situational awareness means being aware of, and understanding your environment and how it changes. It involves understanding the circumstances and planning one's actions to prevent negative outcomes. Here are basic tips to remember:
    - Remain alert and always observe your surroundings. Pay attention and have your head on a swivel.
    - Purses, backpacks and laptop cases should be closed while walking through the parking lot.
    - Avoid using your cell phone while walking.
    - Stay alert and have a mindset of what you would do in an emergency. What to do? Who to call?
    - Plan your emergency exit routes in advance.
    - Intuition – trust your instincts. If you feel something is wrong, don't doubt the feeling. Report it!

4. Mass Notification System

CalOptima Health has deployed the **Everbridge** emergency notification system to ensure that you are kept up to date with critical information in the event of a crisis.

During an emergency, you will receive a combination of notifications, which may include a phone call, e-mail, text message or a notification by way of the Everbridge app. When received, please follow the instructions in the message to confirm. Once you have confirmed the message, the system will stop sending you notifications, unless another message is sent by the system administrators.

All CalOptima Health contact information is automatically loaded to the Everbridge system. You will receive notifications to your CalOptima Health email, desk phone and smart devices even if no further action is taken.
You will receive an e-mail to your CalOptima.org account inviting you to create a

username and password to access the Everbridge member portal. This access will allow you to update your **personal** contact information to the Everbridge system should you wish to receive notification to your personal email, **personal** mobile number, house number.

The e-mail will look like this:

CalOptima Everbridge Member Portal Registration Invitation

DG Dan Greene <noreply@everbridge.net>
To Frias, Patricia

You forwarded this message on 3/18/2021 1:16 PM.

WARNING: This email originated outside of CalOptima. Even if this looks like a CalOptima email, it is not.
DO NOT provide your username, password, or any other personal information in response to this or any other email.
CALOPTIMA WILL NEVER ask you for your username or password via email.
DO NOT CLICK links or attachments unless you are positive the content is safe.

Dear Patricia,
You are invited to create an account in the CalOptima Member Portal.
To get started just click on the link below or paste it into your browser:
Click here to register
Should you have any questions or if you received this invitation in error, please reply to EverbridgeSupport@caloptima.org

Regards,
Your CalOptima Everbridge Team

You may also download the Everbridge App from the Google Play or Apple Store to your **personal** smart devices as another option to create a username and password (if you did not already set up one up on the Everbridge portal), to update personal information ***and*** also receive notifications.

5. When to Call 911

- In the event of an emergency on CalOptima Health property involving a sudden, unexpected incident that poses a clear and imminent danger requiring immediate action to prevent or mitigate the loss or impairment of life, health or property, employees should immediately call 911. Employees should then call the Manager of Environmental Health and Safety or the Director of Facilities to report the emergency.

- If you are ever in doubt of whether a situation is an emergency, you should call 911. It's better to be safe and let the 911 operator determine if you need emergency assistance. The 911 operators are trained to determine the level of emergency and whether emergency personnel should be dispatched.

- The non-emergency phone number for the Orange Police Department is (714) 744-7444. The call takers for the non-emergency line are the same people who answer 911 calls. They too can determine whether your situation is an emergency.

- The CalOptima Health Suicide Task Force (located on the InfoNet) response process is not to be utilized for on-site emergency/crises situations. The Suicide Task force process is intended to provide employees with the necessary assistance while dealing with a member in crises who is <u>**off site**</u>, and on the phone. When the process is activated, additional staff will respond directly to the employee's physical location in need of assistance, and they work together with

911 dispatch in responding to the Member in crises.

- ## Facilities/EH&S E911 Response Process

  "E911" or "Enhanced 911" is a system that automatically provides emergency services with your physical address or location when they receive your 911 call. When 911 is dialed from a CalOptima Health office phone (desktop and soft phone) an E911 alert is sent to Facilities/EH&S team members notifying them that 911 has been dialed. All team members receive alerts on their computer and CalOptima Health issued cellular phones. These notifications are received via text, email, and a visual "pop-up" on computer screens. The notification contains the employee's name, extension, location (cubicle/office number/teleworker status). EH&S maintains the primary responsibility of responding to all E911 alerts. It is both the EH&S and Facilities teams duty to communicate throughout the 911 response process. This is accomplished by whatever means necessary (i.e., person to person, text, email, phone call, etc.).

  Once a 911 notification is received, the responding personnel will attempt to contact the extension 911 was dialed from. If there is no answer from the extension, the responding individual will physically respond to location identified in the alert to confirm the legitimacy of the call. The responding personnel will also send a response email, giving as current an update as possible **(i.e., "there was no response from the extension provided. I am responding to the location now. Please stand by", or "call was for a member, no further action is required", or "call was for an on-site employee, emergency personnel are on the way" etc.),** If the call is an actionable emergency, the responding individual will immediately communicate with facilities, EH&S, and security.

  In an actionable emergency, Facilities staff will stage at the building entrance in preparation of emergency personnel's arrival. Facilities will open corridor doors setting a pathway for emergency responders from the building entrance to the scene. Security will lock down the freight elevator on the ground floor in preparation of emergency personnel arrival. Once they have arrived, Facilities will provide an escort to the scene.

  EH&S will respond to the scene and begin an Accident/Incident report, being sure to also collect the following information:

  - **Time emergency personnel arrived.**
  - **Time emergency personnel left the premises.**
  - **If possible, ask the employee if they have already spoken to their emergency contact on file. If it is unknown, EH&S will contact HR. Either HR or EH&S will call employees emergency contact to give them an update.**
  - **If it is determined the employee needs further medical attention and is taken to the hospital, EH&S must ascertain what hospital the employee being taken to prior to departing the property**.

EH&S shall complete all Incident/Accident reports and save to the EH&S G: drive within 24 hrs. of being made aware of the incident. All incidents that result in an injury shall be shared with HR and reports made available.

After the event has completed, a final email must be sent to the 911 team with a summary of the event **(i.e., "Employee was taken by ambulance, no further action is required", "Employee remained on site, emergency personnel have left the premises, no further action is required")**. This email is usually provided by EH&S, although it is the Facilities team responsibility in the absence of EH&S.

Employee's that inadvertently dial 911 are instructed to remain on the line (do not hang up) and cancel the call with the 911 emergency personnel. **911 personnel greatly appreciate being informed that the call was an error and NOT an emergency!**

6. Evacuation

A building evacuation may be necessary for a variety of reasons: fire, power failure, bomb threat, hazardous spill, structural damage, natural causes (e.g., earthquake, tsunami) or flooding. An evacuation will be initiated by an audible alarm, strobe light, voice alarm via the public address system, email, mass notification system or emergency authority in charge. When an alarm sounds, or an evacuation notice is given, everyone must exit the building. The evacuation procedure pertains to everyone on-site (i.e., temporary employees, full-time employees, visitors, members and contractors). Never question the validity of an alarm! Treat every alarm as it is a real emergency, safely evacuate, and ask questions later.

CalOptima Health has designated and trained select employees as Floor Wardens along with members of their emergency response teams (ERT) to guide and assist employees during an emergency. All employees should know who their Floor Wardens and ERT members are. If you do not know, or haven't met your floor warden, ask your manager or supervisor to be introduced. The floor warden has the authority and knowledge to provide direction and assistance during an emergency. Always follow the instructions given by the floor warden(s) and members of the ERT(s).

IMPORTANT: Always use the nearest stairwell to exit the building and never use the elevator during an evacuation.

Once outside, employees must proceed to the nearest refuge area and immediately report to the floor warden, floor warden alternate or designated emergency response team member. Department heads are encouraged to support the emergency response team with accounting for the employee(s) assigned to them.

Each floor warden shall utilize a current roll call of employees for their designated

floor/area to account for employees in the refuge area. Roll call rosters are submitted to facilities monthly by each Floor Warden. These rosters are retained in the Mailroom and brought to the refuge area by facilities in a post evacuation scenario.

The 505 building operates 3 shifts from Monday 6 am through Saturday 6 am. There are no floor wardens or security guards on site from Saturday 6 am through Monday 6 am. If an employee is on CalOptima property during after business hours , and there is an emergency or unusual occurrence, they must remain calm, follow the established emergency response protocols, use common sense, and take personal responsibility for their own safety. understand that staying calm and personal responsibility for safety is required. It is recommended employees follow the established evacuation process and proceed to the nearest refuge area when safe to do so. Once in the refuge area or a safe distance from the building, and there are no emergency personnel on site, employees should call 911 and inform emergency personnel of what has occurred. At all times follow emergency personnel instructions.

- ## Alarm Sequence in a High Rise

  Please note: The sequence of operations for the Fire, Life Safety systems in the 505 building is designed so that when a smoke detector is activated, only the following floors will see the strobe lights flash and alarm sound:

  - The floor in which the smoke is detected.
  - The floor above the floor where the smoke was detected.
  - The floor below the floor where the smoke was detected.

  For example, if a smoke detector is activated on the 3rd floor, the strobe lights and alarm will only activate on the 2nd, 3rd and 4th floors – not the entire building. This is the standard process in commercial high-rise buildings. The purpose of this function is to avoid unnecessary congestion in the stairwells. If the smoke or fire travels to another floor, the alarms will activate accordingly. Steps that should be followed in the event of an evacuation:

- ## DO's & DON'Ts in an Evacuation

  DO's of an evacuation:

  - Begin evacuation procedures IMMEDIATELY when you hear an alarm. Do not question the validity of the alarm.
  - Keep calm.
  - Go straight to the nearest stairwell and proceed to the ground floor.
  - Walk swiftly down the stairs in a single formation holding the continuous handrail on the right-hand side. In an emergency, the first responders will be coming up on the left-hand side.
  - Remove high heel shoes. Carry them down the stairs until you get to the ground floor.
  - Listen for instructions from the emergency response team and follow them.

- If it’s dark, place your right hand on the continuous handrail and the other hand on the left shoulder of the person in front of you.
- If you require assistance going down the stairs, do inform the floor warden of your assigned floor as soon as possible. In an evacuation, employees requiring assistance/employees unable to evacuate will be required to wait on the landing for rescue personnel.
- If you are in a conference room or away from your cubicle/office, proceed to the nearest stairwell and refuge area. Report to the floor warden of your assigned floor.
- Follow the instructions from the CalOptima Health Emergency Response Team members.

DON’Ts of an evacuation:

- Do not go back to your cube/office to gather personal belongings.
- Do not carry food or drinks into the stairwell. These items can be dropped or spilled, causing slip, trip and fall hazards.
- Do not use an elevator under fire alarm conditions.
- Do not run in the stairwells or walk in double formations.
- Do not text or use your cell phone while walking down the stairwell.
- Do not socialize in the stairwell.
- Do not return to your workstation until the “all clear” is given by the authority in charge.

Once outside, proceed to the nearest refuge area. The north refuge area is in our parking lot closest to Lewis Street. The south refuge area is in the parking lot closest to Esporta Fitness Center (formerly LA Fitness). Immediately upon arrival to the refuge area check in with the emergency response team (floor warden/ floor warden alternate) of your assigned floor . Stay with your assigned floor. Remain in the refuge area and be as quiet as possible so that the emergency response team members can hear instructions from the first responders and/or Facilities.

- **Stairwell protocols:**
  - Move in an orderly fashion quickly but carefully down the stairs.
  - Stay to the right, where there is a continuous handrail for you to hold during your descent.
  - Follow emergency personnel’s instructions if encountered This may include moving to the left side of the stairwell.
  - Take off high-heeled shoes.
  - No food and no drinks in the stairwell during an evacuation.
  - Employees who cannot walk down the stairs should wait for the Fire Department in the landing of the stairwell.
- **When to tore-enter the building:**
  Employees do not re-enter the building until they have received clearance from Facilities, emergency personnel or a designated lead.

- ## Annual Fire Drills

  During fire drills held at CalOptima Health, the entire building will be evacuated all at once as the alarms are activated on every floor.

  Employees who are on site are required to participate and evacuate during all fire drills these steps should be followed:

  - Follow the designated evacuation exit and convene in the assigned refuge area (North or South).
  - Do not call or text other employees and tell them to evacuate.
  - Do not use the elevators. Use the stairwells.
  - Employees must remain with their department/group and assemble at their designated locations.
  - Employees should not re-enter the building until instructed to do so by authorized personnel.

  Rosters of employees requiring assistance and employees unable to evacuate are updated monthly as part of the evacuation roll call process. The roll calls are filed with the respective floor wardens and emergency response team members on both the north and south sides of each floor. Roll calls are also filed in the Mail Room for each of the refuge areas (north and south). Copies of the roll calls are also maintained in the Environmental Health & Safety Department.

- ## Employees Requiring Assistance:

  - Employees requiring assistance stay on the landing inside the nearest stairwell until emergency personnel arrives. It is recommended an assigned employee (assistant) stay on the landing with the employee requiring assistance.

    Floor wardens: when documenting the employees requiring assistance on your roll calls, the following questions must be addressed and documented:
    - Are you able to go down the stairs?
    - Do you have an assigned assistant to remain with you on the landing in the stairwell during an evacuation?
    - If not, is there someone who you would feel comfortable with to remain with you on the landing in the stairwell during an evacuation?
    - An alternate assistant is recommended.

  - The employee requiring assistance and their assistant must stay against the wall & out of the way of traffic.
  - Prior to evacuating, the floor warden or an emergency response team (ERT) member takes the name(s) and headcount of employees remaining in the stairwell.
  - Once outside, these names are given to either Facilities (green vests) or emergency personnel.

- **Employees Unable to Evacuate:**
  - In the rare event both stairwells are blocked, it is recommended the employee retreat to an office or the perimeter near a window.
  - If in the office, call 911. Tell the operator your location.
  - If near a window, call 911. Tell the operator your location. Look out the window, describe to the operator what you see.
    If possible, wave anything (towel, jacket, blanket, paper, etc.) available that may be noticed by emergency personnel on the ground.

7. Telework

CalOptima Health's Telework Program policy (GA.8044) requires teleworkers to set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S). EH&S will verify, through a home office assessment, the standards have been met by the employee prior to beginning the telework assignment. Employees are required to follow the instructions as stated in the Home Office Safety Guidelines.

Contact Environmental Health and Safety with questions or concerns regarding home office safety requirements.

In the event of an evacuation, for accountability purposes, all permanent /partial teleworkers, t, ,employees assigned to other work sites, such as PACE or community work, and visitors are required to sign-in upon arrival and sign-out prior to exiting the 505 building.

8. Types of Emergencies and Unusual Occurrences

The safety and security of CalOptima Health employees, members, visitors and others at, or on, CalOptima Health property are of the utmost importance to CalOptima Health.

CalOptima Health's Unusual Occurrence Policy (GA.8016) and this Emergency Response Plan outline the definitions, requirements, guidance and procedures for emergencies and unusual occurrences.

In the event of an emergency on CalOptima Health property involving a sudden, unexpected incident or unusual occurrence that poses a clear and imminent danger requiring immediate action to prevent or mitigate the loss or impairment of life, health, or property, employees shall immediately call 911. When the 911 call is placed from a CalOptima Health landline, Facilities is automatically notified. Employees shall then call the Manager of Environmental Health and Safety, or the Director of Facilities, to report the emergency such as a:

- **Fire**
  - **If a fire occurs during business hours:**
    - The emergency response teams are responsible for the evacuation of their floor.
    - When an alarm sounds, follow the evacuation procedures.
    - Listen to the emergency response teams' instructions.
    - The emergency response teams and Facilities will direct all employees to calmly proceed to the safe refuge areas.
    - The floor wardens will be sweeping their designated floor.

- **If a fire occurs and evacuation is required:**
  - Take your car keys, cell phone, purse/wallet and other personal items with you.
  - **Do not** attempt to save other personal possessions at the risk of personal injuries.
  - Proceed to the nearest exit/stairwell.
  - When approaching a door to exit the building, before opening, use the back of your hand to feel the temperature of the door handle. If it feels hot or smoke is seeping through it, **do not open it**.
  - Use an alternate means of exiting your location.
  - When outside, proceed to the nearest refuge area.
  - **Do not** go back into a burning building.
  - **Do not** return to the building until instructions have been given by the CFO or Facilities management.

- **If you become trapped in your office and cannot reach a stairwell:**
  - Keep all doors closed.
  - If the telephone landlines are operational, call 9-1-1 to give them your location. You may also use your cellular phone. When calling, be prepared to provide the following information to the dispatcher: your name, telephone number, location of the fire (building address and floor), and additional information of the current situation. Do not hang up until the dispatcher does.
  - Use clothes, blankets, or rugs to seal off cracks under the entrance doors to prevent smoke from infiltrating.
  - Be prepared to draw attention of the rescue crews from an office window. If available, get to a nearby window, place any available items (jacket, blanket, hat, paper, calendar, mousepad, lunch bag, flashlight, etc.) on the window to signal your location to the rescue crews.

- ## Earthquake

  Earthquakes in Orange County may be inevitable. Steps taken before, during and after an earthquake will help make you and everyone around you safer. First and foremost, plan for your personal safety.

  Before an earthquake, be familiar with your immediate work area and floor plan such as the location of fire extinguishers and emergency supplies. Look around your area and decide where the safe spots are located (e.g., under sturdy tables in the kitchen, desk or offices). This will help you react effectively when it is necessary to find the closest and safest shelter point.

  - During an earthquake:
    Everyone should "drop, cover and hold on". Actions during an earthquake don't require immediate evacuation from the building. Employees experiencing an earthquake should follow these guidelines:

- Get under a desk or table immediately.
- Drop down to your hands and knees so the earthquake doesn't knock you down.
- Move away from the danger areas: windows, hanging objects (wall clocks) or unsecured items (plants).
- Cover your head and neck with your arms to protect yourself from falling debris.
- Hold on to any sturdy covering so you can move with it until the shaking stops.
- Keep your back to all glass objects if you cannot avoid them completely.
- Watch for falling objects. Cover your head as much as possible.
- Do not panic. A clear mind will help you through the event.
- If you are outside: stay outside and move to an open area away from the building.
- If you are in an automobile: stay in the car until the shaking stops.

- After the shaking:
  Stay where you are until you hear from the floor warden/floor warden alternate or an announcement over the public address system for additional instructions.

  Be alert for aftershocks. Their intensity can produce further shakes. Respond to the aftershock as though it is the original earthquake.

  If you are trapped in the building:
  - Stay calm.
  - Call 911 and provide your current location.
  - Get to a nearby window, place any available items (jacket, blanket, hat, paper, calendar, mousepad, lunch bag, flashlight, etc.) on the window to signal your location to rescuers.

- **Bomb Threat**
  Most bomb threats are received by phone. Bomb threats are serious until proven otherwise. Act quickly. Remain calm and obtain information with the checklist listed below.

  If a bomb threat is received by phone:
  - Remain calm. Keep the caller on the line for as long as possible. **DO NOT HANG UP**, even if the caller does.
  - Listen carefully. Be polite and show interest.
  - Try to keep the caller talking to learn more information. Write down everything the caller says.
  - If possible, write a note to a colleague to call 911.
  - Copy the number and/or letters of the caller that's displaying on your phone.
  - Complete the Bomb Threat Checklist immediately *(located in the IIPP).* Write down as many details as you can remember. Try to get

exact words.
- Immediately upon termination of the call, do not hang up and call 911 from a different phone. Give the exact location and all known written facts. When the 911 call is placed from a landline, Facilities is automatically notified.

If a bomb threat is received by handwritten note:
- Call 911 immediately.
- Then notify the Manager of Environmental Health & Safety
- Handle notes as minimally as possible.

If a bomb threat is received by e-mail:
- Call 911 immediately.
- Then notify the Manager of Environmental Health & Safety
- Do not delete the message.

If determined by the police that the building should be evacuated, the alarms will sound over the public address system. Follow the evacuation procedure.

- ## Active Shooter/Violent Intruder

An active shooter as defined by the United Stated Department of Homeland Security is an individual actively engaged in killing or attempting to kill people in a confined and populated area. In most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the active shooter and to mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

Evacuate (Run)
If there is an accessible escape path, attempt to evacuate the premises. Be sure to:
- Have an escape route and plan in mind.
- Evacuate regardless of whether others agree to follow.
- Leave your belongings behind.
- Help others escape, if possible.
- Prevent individuals from entering an area where the active shooter may be.
- Keep your hands visible.
- Follow the instructions of any police officers.
- Do not attempt to move wounded people.
- Call 911 when you are safe.

Hide out (Hide)
If evacuation is not possible, find a place to hide where the active shooter is less likely to find you. Your hiding place should:

- Be out of the active shooter's view.
- Provide protection if shots are fired in your direction (i.e., an office with a closed and locked door).
- Not trap you or restrict your options for movement.

To prevent an active shooter from entering your hiding place:

- Lock the door.
- Blockade the door with heavy furniture.

If the active shooter is nearby:

- Lock the door.
- Silence your cell phone and/or pager.
- Turn off any source of noise (i.e., radios, televisions).
- Hide behind large items (i.e., cabinets, desks).
- Remain quiet.

If evacuation and hiding out are not possible:

- Remain calm.
- Dial 911, if possible, to alert police to the active shooter's location.
- If you cannot speak, leave the line open and allow the dispatcher to listen.

Take action against the active shooter (Fight)
As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Acting as aggressively as possible against him/her.
- Throwing items and improvising weapons.
- Yelling.
- Committing to your actions.

HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES
Law enforcement's purpose is to stop the active shooter as soon as possible. Officers will proceed directly to the area in which the last shots were heard.

- Officers usually arrive in teams of four (4).
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment.
- Officers may be armed with rifles, shotguns, and/or handguns.
- Officers may use pepper spray or tear gas to control the situation.
- Officers may shout commands and may push individuals to the ground for their safety.

How to react when law enforcement arrives:

- Remain calm and follow officers' instructions.
- Put down any items in your hands (i.e., bags, jackets).
- Immediately raise hands and spread fingers.
- Keep hands visible at all times.
- Avoid making quick movements toward officers such as holding on to them for safety.
- Avoid pointing, screaming and/or yelling.
- Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises.

Information to provide to law enforcement or 911 operators:

- Location of the active shooter.
- Number of shooters, if more than one.
- Physical description of shooter(s).
- Number and type of weapons held by the shooter(s).
- Number of potential victims at the location.

The first officers to arrive at the scene will not stop to help injured persons. Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

Additional Ways to Prepare and Prevent an Active Shooter Situation Preparedness

- Ensure that your facility has at least two evacuation routes.
- Post evacuation routes in conspicuous locations throughout your facility.
- Include local law enforcement and first responders during training exercises.
  Prevention
- Foster a respectful workplace.
- Be aware of indications of workplace violence and take remedial actions accordingly.

- ## Civil Unrest

  Peaceful demonstrations are not considered civil unrest. Civil unrest is typically defined as a gathering of three or more people, in reaction to an event, with the intention of causing public disturbance. Civil unrest can include unpeaceful protests, riots, demonstrations, looting and the threatening of individuals or assemblies that become disruptive. At all times your personal safety is your responsibility, protect yourself.

When CalOptima Health becomes aware of a civil unrest event, to ensure employee safety.

- CalOptima Health may use the Everbridge mass notification system, to communicate instructions on the response to the disturbance.
- Instructions may include shelter-in-place, evacuations or run, hide, fight.
- Once the disturbance/event is resolved and it is safe for employees, a final mass notification message will be sent.

If an employee observes such disturbances while on CalOptima Health property:

- Call 911 and then call the Manager of Environmental Health & Safety or Director of Facilities
- Do not provoke or become part of the disturbance.
- Secure your work area, log off computers and secure sensitive files, if safe to do so.
- Follow mass notification instructions on the response to the disturbance.

- **Public Health Emergency**

In the event of a public health emergency declaration, CalOptima Health will follow federal, state and county guidance. As exemplified with the most recent COVID-19 pandemic, mandates and procedures for handling a public health emergency are outlined in the Emergency Temporary Standards (ETS) within CalOptima Health's Injury & Illness Prevention Plan as issued by the appropriate federal, state and county agencies, primarily California Department of Public Health and CAL/OSHA. Communications to its employees and CalOptima Health's response to such declarations will be coordinated by the chief executive team, the Executive Director of Human Resources, EH&S Manager, Director of Facilities and the Information Technology Department.

- **Lockdown/Shelter-In-Place**

A Shelter-In-Place notification may be issued when Facilities/building management determines that there is a potential threat outside the building and it is safer to remain in the building than to evacuate. Employees will receive a combination of notifications from CalOptima Health, which may include a phone call, e-mail, text message or a notification by way of the Everbridge app. Take the notification seriously and follow instructions.

How to Shelter-In-Place?

- REMAIN CALM!
- Depending on the emergency, you may be instructed to locate to an interior room with the fewest windows (i.e., conference rooms, breakrooms, copy rooms).
- There also may be instructions to remain at your workstation or gather in a specified location.
- Instructions may include locking or barricading the door.
- If there are other employees, members, or visitors unaware of the

notification, and is safe to do so, take the time to relay the instructions in the notifications. If necessary for concealment, turn off lights, silence phones and keep as quiet as possible.

- Move away from doors and windows.
- Move/use furniture to provide added protection if necessary.
- Follow instructions from the emergency response teams (floor wardens), Facilities, Security and the first responders.
- When safe to do so, Facilities & Support Services Coordinators will continue to sweep their floors, keeping occupants calm and giving updates to key personnel as they receive it.
- The Director of Facilities will update the EMT Chief (CFO).
- During the lockdown or shelter-in-place order, the building security guards will remain at their respective posts unless directed by the property manager to do otherwise.
- DO NOT leave until an all-clear message is received.

What if you're outside?

- If you are outside during a Shelter-In-Place emergency, you should seek shelter in a nearby building.
- If you are unable to get inside a building, seek nearby shelter (e.g., large trees, walls, cars in a parking lot/garage) away from the danger area (if known).
- Follow instructions from the emergency response teams, Facilities, Security and first responders.
- Stay sheltered until an all-clear message is received.

- ## Medical Emergency

If a life-threatening injury/illness occurs at CalOptima Health property:

- Dial 911 immediately using an internal landline (desktop and soft), then provide all information requested by the emergency operator, including exact location within the building. When the 911 call is placed from a landline (desktop and soft) within the building, an E911 alert is sent to facilities/EH&S team members notifying them that 911 has been dialed.
  - ➢ All team members will receive alerts on their computer and CalOptima Health issued cellular phones. The notifications are received via text, email, and a visual "pop-up" on computer screens. The notification contains the employee's name, extension, location (cubicle/office number/teleworker status).
  - ➢ This information is used to assist guiding emergency services to the location as quickly as possible.
- CalOptima Health provides first aid kits and AEDs on every floor. These tools are available to any trained staff member who chooses to assist in a medical emergency.
- **Note**: Employees have no obligation or are required to provide CPR or administer first aid.

- The responding staff will remain with the injured employee until emergency personnel arrive.

If a non-life-threatening injury/illness occurs at CalOptima Health:
- If an injury occurs, and it requires basic first aid only (i.e., minor cut, laceration, bruises) an employee will attend to the injury and obtain necessary supplies from the nearest first aid kit.
- Employee will notify his or her supervisor/manager immediately, then the Environmental Health & Safety Department to provide information regarding the injury/illness.
- Immediately report any injury to employee's supervisor/manager, then to the Environmental Health & Safety Department.

- **Unusual Occurrences**

  In the event of an unusual occurrence where there is a perceived emergency on CalOptima Health property involving a sudden, unexpected incident that poses a clear and imminent danger requiring immediate action to prevent or mitigate the loss or impairment of life, health, or property, call 911. When the 911 call is placed from the CalOptima Health landline, Facilities is automatically notified. Then, call the manager of Environmental Health and Safety or the Director of Facilities to report the incident.

  Unexpected incidents and unusual occurrences are events that rarely happen in the work environment but require preparation and an emergency response plan to ensure the safety of all CalOptima Health Employees, Members, and visitors. The following non-exclusive list of emergencies, unexpected incidents and unusual occurrences is intended to give guidance and requirements for preparation and response should the situation be encountered:

- **Elevator Entrapment**

  In the event of an elevator entrapment, each elevator has a telephone that is directly connected to the elevator dispatching company.

  1. Remain calm.
  2. Push the emergency telephone button.
  3. Wait for the elevator dispatcher to respond and report the reason for your call.
  4. Do not try to climb out of the elevator without emergency personnel direction and assistance.

- **Power Outage & Blackouts Facilities**

  Responses to Power Outages

  1. **Determine Outage Cause and Emergency Level**
     - The building Property Manager is the subscriber of record with Southern California Edison (SCE) and will be the recipient of notifications and updates of blackouts from SCE via telephone or email.

- Upon notification of a blackout from SCE, the Property Manager will immediately contact the Director of Facilities to give a situational update.
- The Director of Facilities will update the Emergency Management Team (EMT) Chief (CFO) and the EH&S Manager throughout the power outage and until power is restored.
- The Director of Facilities will maintain communications throughout the power outage with the building Property Manager to obtain situational updates.
- The Director of Facilities will maintain communications with the Information Services (IS) Crisis Team Leader (IS Director) on situational updates regarding power in the MDF and IDF rooms. Coordination with the Orange County Data Center is the responsibility of the IS department.
- The IS Crisis Team Lead will continue to update the Chief Information Officer (CIO) throughout the duration of the blackout/ power outage.
- The EMT Chief will refer to the CalOptima Health BCP activation flow chart to determine appropriate emergency level and appropriate communication method to employees.

2. All Users Secure Motorola Radios

- If practical, all members of the Facilities team, EH&S Manager, floor wardens and EMT Chief will return to their respective workstations and retrieve their Motorola radios.
- Use the following Motorola channels for emergency communications during a power outage and/or blackout.

  Channel 1: south side
  Channel 2: north side
  Channel 3: Emergency management team & Facilities management

3. Facilities & Support Services Coordinators Sweep Building

- Facilities and Support Services Coordinators will report to their assigned floors according to the “Floor Schedule”.
- Facilities and Support Services Coordinators assigned to the first floor will proceed to the Customer Service (Reception), first floor lobby, assembly and conference rooms to provide assistance.
- Facilities Support Services Coordinators will begin sweeping their assigned floors checking closets, restrooms, conference rooms and offices for anyone who may need assistance returning to their work areas.
- The building security guards will maintain their posts in the lobby on the ground floor and will follow the direction of the building Property Manager.
- Those employees or tenants who are able to use the stairs and

return to their work areas will be allowed to do so.

- If the EMT Chief determines an evacuation is necessary, the announcement to evacuate will be made via the mass notification system. In the event the mass notification system is unavailable, the Director of Facilities will notify the floor wardens via Motorola radios. Evacuations will be systematically controlled by floor. Employees will be instructed to gather in the refuge area in the parking lot until further direction is given from Facilities. Roll call will be taken by the floor wardens.

505 Building Systems During a Power Outage

Number	Issue	Tips and Information
1	Location of Employees	During a power outage, all employees are instructed to shelter-in-place. The EMT Chief will determine if and when employees should evacuate. Floor Wardens will be responsible for announcing the evacuation to employees.
2	Lighting	In the event of a blackout, the normal lighting system will become inoperable and the emergency lighting system will illuminate exits and corridors. The emergency lighting, along with the light from the windows will provide enough light to exit the building safely. At night, the emergency lighting will allow safe exiting of the building. Aisles, exits and entrances are to be kept clear at all times to avoid trip hazards and clear exiting.
3	Security	The electronic swipe card system is on a battery backup that will last approximately two hours after a power outage. Electronic swipe card locks will fail in the locked position once the battery backup is drained of its charge. This means the corridor doors will automatically lock and swipe cards will be disabled.
4	Fire Life Safety Systems	These devices are supported by the emergency generator.
5	Emergency Generator	The 505 building has an emergency generator for critical building support systems such as emergency lighting, elevators, fire sprinkler pumps, and fire-life safety systems. The generator will start automatically within moments of a power loss and assume emergency loads. The Building Engineer is responsible for monitoring and running this system. The emergency generator does not support any computer equipment.

Number	Issue	Tips and Information
6	Plumbing/Sewer	Buildings with multiple floors have booster pumps on the city water system that may not function in a power outage. This would cause a loss of water pressure on upper floors. In such situations, employees and other building occupants are asked to refrain from using the restrooms.
7	Ventilation	During a power outage, heating, ventilating, and air conditioning systems will cease to operate until power is restored. The building will generally remain tenable for one (1) hour or less depending on the outside air temperature. The decision to evacuate will be made by the EMT Chief.
8	Communications	The phones will remain operable as long as the Uninterrupted Power Supply (UPS) is operational. The UPS power is available for up to 2 hours. 2Emergency red landline phones per floor (generally located on the north and south end) will be operational and available for 911 calls only.
9	Stairs	During a power outage, use the stairs only. The stairwells will be illuminated just as they are under normal working conditions. If the EMT Chief announces an evacuation, the Facilities team will direct Floor Wardens accordingly and employees will be directed to evacuate the building systematically (by floor).
10	Elevators	Three of the passengers and the freight elevators will be inoperable during a power outage. One passenger elevator will operate on emergency power. This elevator will be used only for individuals requiring assistance to exit the building. Access to the emergency elevator will be supervised by the building Property Manager.
11	Leaving the Workplace	Employees will be directed to vacate the premises when the EMT Chief makes the announcement to do so. The EMT Chief will receive status updates from the Facilities Director. The Facilities Director will work with the property manager on updates regarding duration of outage. The announcement to evacuate will be made via the mass notification system or to the Floor Wardens through the Motorola radios. Members needing assistance will be escorted by building Security or a capable employee. Visitors will be escorted by their CalOptima Health host.

Number	Issue	Tips and Information
12	Returning to the Workplace	If the facility is evacuated due to a long-term power outage, the EMT Chief will record a status message according to tab three (3) of the CalOptima Health Business Continuity Plan (BCP). Employees will receive further instructions regarding incident status and information on returning to work through CalOptima Health's mass notification system, Everbridge,

- ## Hazardous Materials

  Hazardous materials are substances that are flammable, combustible, explosive, toxic, noxious, corrosive, oxidizable, irritants or radioactive.

  In the unlikely event of a hazardous materials accident occurring within close proximity of your workstation or when you become aware of such an event:

  1. Clear the area.
  2. Immediately notify the EH&S Manager or Facilities Director.
  3. Do not attempt to clean up.
  4. Stay away from the area until given an all clear to return.
  5. If an evacuation is necessary, employees are to follow the Evacuation procedures above.

- ## Suspicious Package/Letter

  If you have any reason to believe that a letter or parcel is suspicious, **DO NOT** take a chance; report immediately to the Manager of Environmental Health & Safety

  - **DO NOT** touch the package or object.
  - **DO NOT** tamper with the package or object.
  - **DO NOT** attempt to move the package or object.
  - **DO NOT** open the package or object.
  - **DO NOT** put the package or object in water or an enclosed space, such as a drawer or box.
  - Isolate the package or object and evacuate the immediate area.

  - **Characteristics of Suspicious Packages**
    - Special deliveries, foreign mail, or air mail.
    - Restrictive markings such as "Confidential" or "Personal."
    - Excessive postage.
    - Handwritten or poorly typed addresses.
    - Incorrect titles.
    - Misspelled words.
    - Stains or discoloration on the package.

- Excessive weight.
- Rigid, lopsided, or uneven envelopes.
- Protruding wires or aluminum foil.
- Excessive tape or string.
- Visual distractions such as illustrations.
- No return address.

9. Emergency Response Team Roles & Responsibilities

- ## Floor Warden & Floor Warden Alternate Responsibilities:
  - The primary duty of the floor warden/floor warden alternate is to ensure an orderly, prompt and safe evacuation.
  - Lead the emergency response team (ERT) for the assigned floor section.
  - Know the responsibilities of the emergency response team and ensure that all are trained in their responsibilities.
  - Ascertain the assignment of the buddy system for the employees requiring assistance/employees unable to evacuate.
  - Keep roll call up to date. Submit monthly roll calls to Environmental Health & Safety.
  - Be familiar with the assigned floor areas, exit routes and refuge areas.
  - Inform new employees and newly relocated employees of the evacuation process (exit routes, refuge areas, buddy system, etc.), the emergency response team (ERT) members and how to access help.
  - Communicate changes (roll call, buddy system, emergency team member, etc.) with your emergency response team members and EH&S.
  - Perform monthly radio checkup.

- ## Evacuation process:
  - When the fire alarm sounds, quickly sweep your assigned area and inform all occupants that evacuation is required. Remind occupants of the closest stairwell and safe refuge area.
  - Remember to check all offices, isolated rooms, (MDF, IDF, files, storage) and restrooms. Before opening the doors, check the temperature of the handle with the back of your hand to make sure it is not hot. If the door handle is hot, do not open the door as there may be fire behind the door. When the room is cleared, close the door and place a post-it on the door. The post-it note indicates to the fire department that the office has been checked and cleared. It also helps prevents fire spread, as well as limiting the spread of smoke and toxic gases.
  - Make note of occupants remaining on the floor, including the ones on the landing who are unable to evacuate. In the event of an actual emergency, this information must be reported to Facilities, who in turn will report to the first responders. Refer to the Employees Requiring Assistance/Employees Unable to Evacuate procedure.

- After completing the sweep of your assigned area, exit the building and proceed to the safe refuge area.

- **Traffic monitor & traffic monitor alternate's responsibilities:**
  - Check the elevator lobby area to ensure no one is waiting for an elevator.
  - When approaching the elevator lobby area, the doors should be closed. Before opening the doors, check the temperature of the handle with the back of your hand to make sure it is not hot. If the door handle is hot, do not open the door as there may be fire behind the door.
  - Once the elevator lobby is secure, direct the flow of traffic away from the elevators. Stand in the hallway outside the elevator lobby doors, direct traffic toward the stairwell exits.
  - Make sure food and drinks are left in the hallway corridor, not in the stairwell.
  - When traffic in the hallway subsides, exit the building to the safe refuge area.
  - Check in with the floor warden and/or floor warden alternate of your floor. Support their roll call process.

- **Stairwell monitor & stairwell monitor alternate's responsibilities:**
  - When approaching a door to exit the building, before opening, use the back of your hand to feel the temperature of the door handle. If it feels hot or smoke is seeping through it, do not open it. Use alternate means of exiting your location.
  - When safe, stand on the landing and direct the f low of traffic.
  - Keep the door closed as much as possible during an evacuation.
  - Ensure employees do not carry food or drinks down the stairwell.
  - Remind employees to stay in a single line formation on the right-hand side of the stairwell. The right-hand side has the continuous handrail. In an emergency, the first responders will be coming up the left-hand side of the stairs.
  - Remind employees that they must remove high heels and carry them down the stairs.
  - If it's dark, instruct the employees to place the right hand on the continuous handrail and the left hand on the left shoulder of the person in front of them.
  - Document description (gender, clothing, location) of the employees remaining on the landing and report this information to the floor warden/floor warden alternate.
  - When traffic in the stairwell subsides, exit the building and proceed to the safe refuge area.
  - Check in with the floor warden and/or floor warden alternate of your floor. Support their roll call process.

10. Emergency Equipment Locations by Floors

Emergency equipment (Emergency Preparedness Kits, fire alarms, fire extinguishers, AEDs, red phones (911) and first aid cabinets) are installed on each floor at various locations throughout the building. Floor plans with each of these locations are available on the InfoNet.

InfoNet>Departments>Finance>EnvironmentalHealthandSafety>Emergency Response>EmergencyResponsePlan>EmergencyEquipment

11. Map of Refuge Areas

The north refuge area is in our parking lot closest to Lewis Street.
The south refuge area is in the parking lot closest to Esporta (formerly LA Fitness).

Map of the refuge areas are available on the InfoNet.
InfoNet>Departments>Finance>EnvironmentalHealthandSafety>Emergency Response>EmergencyResponsePlan>Site Plan Refuge Areas

12. Training

All new hire employees are required to attend CalOptima Health's new hire orientation and receive introductory safety and security training from EH&S and the Facilities departments. This includes information on the evacuation process, building COVID-19 protocols, cubicle power usage, e.g., what type of electrical appliances are allowed, CalOptima Health's Injury and Illness Prevention Plan (IIPP), general safety and security information, security access card usage, violence in the workplace information, and 911 information and response protocols.

All CalOptima Health employees are encouraged to utilize the safety training available through CalOptima Health University located on their desktops. This learning management system has hundreds of safety topic selections available to CalOptima Health's employees. As CalOptima Health determines safety topics/programs/training for its employees that are required or programs in need of improvement or enhancement, the EH&S department will communicate to the workforce accordingly and mange this process. If there are specific questions regarding anything safety related, employees are encouraged to contact the EH&S Manager.

WORKPLACE ACTIVE SHOOTER RESPONSE AND PREVENTION

An active shooter as defined by the United States Department of Homeland Security is an individual actively engaged in killing or attempting to kill people in a confined and populated area. In most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the active shooter and to mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. **Evacuate**
   If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

   - Have an escape route and plan in mind.
   - Evacuate regardless of whether others agree to follow.
   - Leave your belongings behind.
   - Help others escape, if possible.
   - Prevent individuals from entering an area where the active shooter may be.
   - Keep your hands visible.
   - Follow the instructions of any police officers.
   - Do not attempt to move wounded people.
   - Call 911 when you are safe.

2. **Hide**
   If evacuation is not possible, find a place to hide where the active shooter is less likely to find you.

   Your hiding place should:
   - Be out of the active shooter's view.
   - Provide protection if shots are fired in your direction (e.g., an office with a closed and locked door).
   - Not trap you or restrict your options for movement.

   To prevent an active shooter from entering your hiding place:
   - Lock the door.
   - Blockade the door with heavy furniture.

   If the active shooter is nearby:
   - Lock the door.
   - Silence your cell phone and/or pager.
   - Turn off any source of noise (e.g., radios, televisions).
   - Hide behind large items (e.g., cabinets, desks).
   - Remain quiet.

   If evacuation and hiding out are not possible:
   - Remain calm.
   - Dial 911, if possible, to alert police to the active shooter's location.
   - If you cannot speak, leave the line open and allow the dispatcher to listen.

3. **Take action against the active shooter**
   As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

   - Acting as aggressively as possible against him/her
   - Throwing items and improvising weapons
   - Yelling
   - Committing to your actions

HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES

Law enforcement's purpose is to stop the active shooter as soon as possible. Officers will proceed directly to the area that the last shots were heard.

- Officers usually arrive in teams of four.
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment.
- Officers may be armed with rifles, shotguns, and/or handguns.
- Officers may use pepper spray or tear gas to control the situation.
- Officers may shout commands and may push individuals to the ground for their safety.

How to react when law enforcement arrives:

- Remain calm and follow officers' instructions.
- Put down any items in your hands (e.g., bags, jackets).
- Immediately raise hands and spread fingers.
- Keep hands visible at all times.
- Avoid making quick movements toward officers such as holding on to them for safety.
- Avoid pointing, screaming and/or yelling.
- Do not stop to ask officers for help or directions when evacuating, just proceed in the direction from which officers are entering the premises.

Information to provide to law enforcement or 911 operators:

- Location of the active shooter
- Number of shooters, if more than one
- Physical description of shooter(s)
- Number and type of weapons held by the shooter(s)
- Number of potential victims at the location

The first officers to arrive to the scene will not stop to help injured persons. Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

Additional Ways to Prepare For and Prevent an Active Shooter Situation

Preparedness

- Ensure that your facility has at least two evacuation routes.
- Post evacuation routes in conspicuous locations throughout your facility.
- Include local law enforcement and first responders during training exercises.

Prevention

- Foster a respectful workplace.
  Be aware of indications of workplace violence and take remedial actions accordingly.

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

10. Authorize Amendments to the CalOptima Health Program of All-Inclusive Care for the Elderly Home Care Ancillary Fee-For-Service Contracts

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Authorize the Chief Executive Officer to negotiate and execute rate amendments to the CalOptima Health Program of All-Inclusive Care for the Elderly Home Care Ancillary Fee-For-Service provider contracts, effective September 1, 2024, not to exceed funding incorporated in the Fiscal Year 2024-25 CalOptima Health PACE Operating Budget.

Background and Discussion

CalOptima Health currently contracts with home care ancillary providers on a fee-for-service (FFS) basis to render services such as personal care and chores, supplemental protective supervision, respite in-home care, and transportation services to CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) members. These contracts are extended to providers who successfully meet all CalOptima Health's credentialing and participation requirements.

CalOptima Health seeks to ensure continued access for PACE members to a comprehensive network of home care ancillary providers that provide vital services allowing PACE members to remain safely in their homes. In support of CalOptima Health's existing and future home care ancillary network, staff believe it is necessary to increase reimbursement rates equitability for home care providers that provide services to PACE members.

Staff requests authority to negotiate and amend PACE home care ancillary contracts to reflect rate increases and align rates with the local market for providers rendering similar services.

Fiscal Impact

The recommended action is a budgeted item with no additional fiscal impact beyond what has been incorporated in the FY 2024-25 CalOptima Health Operating Budget.

Rationale for Recommendation

The above requested action will support continued access for PACE members to a comprehensive network of home care ancillary providers who render vital services allowing PACE members to remain safely in their homes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Amendment to Ancillary Services Contract for certain providers

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

AMENDMENT X to

ANCILLARY SERVICES CONTRACT FOR NON-MEDICAL PROVIDER

This Amendment X to the Ancillary Services Contract, Non-Medical Provider ("**Amendmen**t") is effective as of September 1, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and PROVIDER ("**Provider**"). CalOptima and Provider may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Provider have entered into an Ancillary Services Contract, Non-Medical Provider originally effective July 1, 2021, and subsequently amended July 1, 2022, and January 1, 2024, ("**Contract**"), under which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Attachment A, Contracted Services, of the Contract in its entirety and replace it with the new Attachment A, Contracted Services, attached to this Amendment and incorporated into the Contract by this reference.

2. Delete Attachment C, Compensation, of the Contract in its entirety and replace it with the new Attachment C, Compensation, attached to this Amendment and incorporated into the Contract by this reference.

3. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

4. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[*signature page follows*]

Draft pending board approval

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROVIDER:	FOR CALOPTIMA:
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

Draft pending board approval

ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Program. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

_______ Medi-Cal Programs

_______ Medicare Advantage Program (OneCare)

__X__ PACE Program

__X__ Multipurpose Senior Services Program (MSSP)

Draft pending board approval

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means those items and services as defined under applicable CalOptima Programs and CalOptima Policies and required to be furnished under this Contract, and provided to Members who are authorized to receive such items and services including:

2.1.1 Personal Care and Supportive Services

a. **Supplemental Homemaker Services**: Household support and completion of light tasks such as cleaning, laundry, food preparation, household maintenance. Does not include heavy duty cleaning.

b. **Supplemental Personal Care**: Assistance to maintain bodily hygiene, personal safety, and activities of daily living; direct (non-medical) personal care to Member such as feeding, bathing, oral hygiene, grooming, dressing, repositioning, assisting the individual with walking.

c. **Supplemental Protective Supervision**: Supervision in the absence of the usual care provider to Members in their own homes who are very frail or otherwise may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency.

d. **Respite-In-Home**: The purpose is to relieve the Member's caregiver and therefore prevents breakdown in the informal support system.

e. **Transportation**: Transportation to enable Member to gain access to Covered Services and other community services, activities, and resources. Includes transportation escort, if necessary, to assure the safe transport of the Member.

2.1.2 Provider's Active Employee Record for each staff member shall contain the following:

a. Employment application

1. Full Name
2. Social Security Number
3. Date of Employment
4. Date of Birth
5. Home Address
6. Educational Background
7. Type of Employment (Full time, part time, volunteer, or other)
8. Previous Employment experience indicating dates employed.
9. Proof of receiving in-service training in first aid and cardiopulmonary resuscitation within the first six months of employment.
10. A background check completed prior to their date of hire.
11. An OIG exclusion check is completed prior to their date of hire.
12. Documentation that personnel have current and active licensure if licensure is required for their position.
13. Chest X-ray or test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA) performed not more than 12 months prior to employment or within 7 days of employment.
14. Health examination signed by the examining physician or person lawfully authorized to perform such examination which indicates.
    i. Employee is physically qualified to perform duties.
    ii. Employee is free from any condition that would create a hazard to self or others.
    iii. Personnel with direct participant contact were medically cleared of communicable diseases before engaging in direct participant contact.
15. Documentation that personnel completed the following CalOptima PACE specific trainings.
    i. Orientation to the PACE program
    ii. Participant Bill of Rights
    iii. Grievance and Appeals Process
16. Skills competencies to be completed both BEFORE providing any independent care to PACE participants, as well as annually.

Draft pending board approval

ATTACHMENT C
COMPENSATION

1. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and laws, and Provider shall accept as payment in full from CalOptima for services provided under this Contract the amounts set forth in this Attachment C.

2. Payment

2.1 Medi-Cal Program Reimbursement

Not Applicable to this Contract

2.2 OneCare Program Reimbursement

Not Applicable to this Contract

2.3 PACE Program Reimbursement

For PACE Members, CalOptima shall reimburse for Covered Services as follows:

Type of Service	Unit Type	Unit Rate	Mileage
Supplemental Homemaker Services	Hour		See note[1]
Supplemental Personal Care	Hour		n/a
Supplemental Personal Care	Visit[2]		n/a
Supplemental Protective Supervision	Hour		n/a
Supplemental Protective Supervision	Day[3]		n/a
Respite-In-Home	Hour		n/a
Respite-In-Home	Day[3]		n/a
Transportation	Hour		See note[1]

[1] Mileage only applies when client is transported. Reimbursement for mileage shall be calculated at the Internal Revenue Service's published per mile rate for business use for the date of service.

[2] Visit rate is applicable to bathing services only.

[3] Day rate is for 24-hr shift.

Holiday Rate
CalOptima shall pay one and one-half the regular unit rate listed above for services provided on the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas.

Show-up Rate:
Provider shall notify CalOptima PACE within 24 hour when a scheduled service was not provided to client due to any of the following reasons:

a) Client declined service upon caregiver's arrival.
b) Client was not present upon caregiver's arrival.
c) Client cancelled service less than 2 hours before the scheduled shift or visit.

Draft pending board approval

CalOptima's payment for a show-up rate is contingent upon CalOptima PACE's confirmation with client that services were not provided due to one of the reasons listed above.

Additional Provisions:
Provider will not be paid for caregiver's personal travel time to or from the Member's home, unless travel is included as part of the authorized services provided, e.g. shopping or transportation/escort.

Invoicing
Provider shall submit to CalOptima an accurate, complete, descriptive, and timely invoice that includes, but is not limited to, Member Name, Member identification number, description of services, date(s) of service, and hours of service. An invoice may not be submitted before the delivery of service. Provider agrees to submit invoice to CalOptima within fifteen days after the end of the month in which the authorized services were provided. Invoices not submitted within ninety (90) days after the service is rendered are not payable. Provider agrees to submit invoices to CalOptima PACE via secure e-mail to PACEContracting@caloptima.org or via mail to the following address: PACE Center, Attention: Invoice, 13300 Garden Grove Blvd, Garden Grove, CA 92843

2.4 MSSP Program Reimbursement

For MSSP Members, CalOptima shall reimburse for Covered Services as follows:

Service Code	Type of Service	Unit Type	Unit Rate	Mileage
3.1	Supplemental Homemaker	Hour		See note[1]
3.2	Supplemental Personal Care	Hour		n/a
3.2	Supplemental Personal Care	Visit[2]		n/a
3.7	Supplemental Protective	Hour		n/a
3.7	Supplemental Protective	Day[3]		n/a
5.1	Respite-In-Home	Hour		n/a
5.1	Respite-In-Home	Day[3]		n/a
6.3	Transportation	Hour		See note[1]

[1] Mileage only applies when client is transported. Reimbursement for mileage shall be calculated at the Internal Revenue Service's published per mile rate for business use for the date of service.

[2] Visit rate is applicable to bathing services only.

[3] Day rate is for 24-hr shift.

Holiday Rate

CalOptima shall pay one and one-half the regular Unit rate listed above for services provided on the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas.

Show-up Rate:

Provider shall notify CalOptima MSSP within 24 hours when a scheduled service was not provided to client due to any of the following reasons:

Draft pending board approval

a) Client declined service upon caregiver's arrival.
b) Client was not present upon caregiver's arrival.
c) Client cancelled service less than 2 hours before the scheduled shift or visit.

CalOptima's payment for a show-up rate is contingent upon CalOptima MSSP's confirmation with client that services were not provided due to one of the reasons listed above.

Additional Provisions:
Provider will not be paid for caregiver's personal travel time to or from the Member's home, unless travel is included as part of the authorized services provided, e.g. shopping or transportation/escort.

Invoicing
Provider shall submit to CalOptima an accurate, complete, descriptive, and timely invoice that includes, but is not limited to, Member Name, Member identification number, description of services, date(s) of service, and hours of service. An invoice may not be submitted before the delivery of service. Provider agrees to submit invoice to CalOptima within fifteen days after the end of the month in which the authorized services were provided. Invoices not submitted within ninety (90) days after the service is rendered are not payable. Provider agrees to submit invoices to CalOptima MSSP via secure e-mail to MSSPinvoices@caloptima.org or via mail to the following address: CalOptima- MSSP Department, Attention: Invoice, 505 City Parkway West, Orange, CA, 92868.

Draft pending board approval

3. **Payment Procedures**.

3.1 Health Network. If a Health Network is financially responsible under its contract with CalOptima for the services a Provider rendered to a Member, Provider shall look solely to Health Network for payment for those services, and CalOptima and Member shall not be liable to Provider for those services.

3.2 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Provider shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.3 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Med-Cal or Medicare, as applicable, when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal or Medicare fee schedule, as applicable, at the time of service are not reimbursable.

3.4 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.5 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and laws.

3.6 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and laws.

3.7 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

Draft pending board approval

CalOptima Health Board Action Agenda Referral

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

Consent Calendar
11. Approve Modifications to Policy GA.3201: Document Management Program

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

Recommended Actions
1. Approve modifications to Policy GA.3201: Document Management Program.
2. Authorize the Chief Executive Officer to maintain and update the attachment for GA.3201, CalOptima Health Document Retention Schedule, to comply with statutory and regulatory requirements, and to support operations.

Background
Policy GA.3201 establishes guidelines for maintaining a Document Management Program and was last updated on August 1, 2018. The policy includes a Document Retention Schedule (Schedule), which addresses the type of records that CalOptima Health is required to retain by responsible department, the duration of the retention, the citation or rationale for the requirement, and the final disposition of the records. The Schedule includes written, printed, or electronic records that contain confidential or non-confidential information. The Schedule adheres to state and federal laws, regulations, contracts, and any additional requirements by CalOptima Health or by agencies that oversee CalOptima Health.

Discussion
Staff, with the assistance of outside general counsel, reviewed and revised the Schedule to ensure it aligns with federal and state statutory and regulatory requirements. Staff recommends the Board of Directors (Board) approve retiring the current version of the Schedule and approve the new Schedule attached to Policy GA.3201, effective upon the Board's approval. The policy itself remains unchanged apart from some non-substantive, minor clarifying language updates. In addition, staff requests that the Board authorize the Chief Executive Officer to maintain and update the Schedule to ensure compliance with statutory and regulatory requirements, and to support CalOptima Health operations.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
The proposed revisions to Policy GA.3201: Document Management Program aligns the policy and Schedule with current operations and ensures compliance with state regulations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. Policy GA.3201: Document Management Program

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Policy: GA.3201
Title: **Document Management Program**
Department: Facilities
Section: Not Applicable

CEO Approval: /s/

Effective Date: 04/07/1998
Revised Date: 08/01/2024

Applicable to:
☐ Medi-Cal
☐ OneCare
☐ PACE
☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

This policy establishes guidelines for CalOptima Health's Document Management Program.

II. POLICY

A. CalOptima Health shall establish and maintain a Document Management Program to control the organization, utilization, storage, retention, retrieval, and eventual ~~disposition~~ disposal of all print and electronic information created by CalOptima Health.

B. CalOptima Health shall develop and maintain a Document Retention Schedule to cover all Documents created, used, and received by CalOptima Health during the normal course of business. The Document Retention Schedule shall adhere to state and federal laws, regulations and contracts, as well as requirements by CalOptima Health and the agencies that oversee CalOptima Health.

C. CalOptima Health shall protect all confidential documents including, but not limited to, Protected Health Information (PHI), from unauthorized Disclosure in accordance with federal and state law.

D. CalOptima Health shall destroy confidential Documents in accordance with this Policy, and only by a bonded document-destruction service provider.

E. CalOptima Health may destroy non-confidential Documents by recycling or deleting in accordance with the Document Retention Schedule.

III. PROCEDURE

A. The Facilities Department shall be responsible for the physical components of the~~managing and administering the~~ Document Management Program. Specifically, the Facilities Department shall:

~~1. Maintain the Document Retention Schedule;~~

~~2.~~1. Provide and manage a contract with an off-site storage vendor for the purpose of continued retention of Documents, in accordance with CalOptima Health's Document Retention Schedule;

~~3.~~2. Provide and manage a contract with a vendor for the destruction of Documents slated for

destruction, in accordance with CalOptima Health's Document Retention Schedule;

4. Serve as a liaison with CalOptima's Information Services (IS) Department regarding processes associated with management of electronic documents;

5.3. Serve as a liaison with the off-site storage vendor and facilitate the transfer and retrieval of Documents with the off-site storage vendor; and

6. Serve as a liaison with the vendor for the destruction of Documents and facilitate the destruction of Documents with the vendor.; and

7.

8.4. Facilitate an annual audit of CalOptima's Document Retention Schedule with all departments.

B. The Information Technology Services (ITS) Department shall be responsible for the electronic components of the Document Management Program, including:

1. Manage processes associated with electronic documents;

2. Maintain the Document Retention Schedule; and

3. Facilitate an annual audit of CalOptima Health's Document Retention Schedule with all identified departments.

B.C. Each CalOptima Health department shall be responsible for managing and maintaining its Documents in accordance with the Document Retention Schedule and the terms and conditions of this Policy.

1. A department director shall appoint and maintain a Document coordinator within the department to manage the department's Documents. The Director shall provide the Facilities ITS Department with the name and extension of the acting Document Coordinator.

2. The Document coordinator shall:

   a. Have overall responsibility for the department's Documents, the location of the Documents, and the contents of all boxes sent to off-site storage;

   b. Select Documents for transfer to storage in accordance with the department's Document Retention Schedule and work with the Facilities Department and the department to transfer the Documents to off-site storage;

   c. Select Documents for destruction in accordance with the department's Document Retention Schedule and work with the Facilities and ITS Departments to coordinate destruction;

   d. Obtain the appropriate authorization signatures for transferring or destroying Documents and return the Certificate of Destruction to the Facilities Department in a timely manner;

   e. Assist his or her department staff with requesting the retrieval of Documents from off-site storage;

   f. Participate in the review and revision of the Document Retention Schedule on an annual basis; and

For 20240801 BOD Review Only

g. Participate in the annual audit of CalOptima Health's Document Retention Schedule.

C.D. Document Retention Schedule

1. Each department shall follow the Document Retention Schedule that shall cover all essential types of Documents created, used, and received in such department during the normal course of business.

2. The Document Retention Schedule shall adhere to state and federal laws, regulations and contracts, as well as requirements by CalOptima Health and the agencies that oversee CalOptima Health.

D.E. Document Destruction

1. Documents that are stored within a department for the duration of their retention period shall be disposed of by the department on at least an annual basis.

2. All confidential documents shall be destroyed by the bonded document destruction company contracted by CalOptima Health by shredding, or other secure means, as designated by CalOptima Health.

3. CalOptima Health staff shall be supplied with secured receptacles for document shredding.

4. All non-confidential Documents shall be destroyed by recycling.

5. The Facilities and ITS Departments will issue forms documenting the destruction of all Documents by all departments by whichever manner is appropriate.

6. Destruction Documents shall be maintained by the Facilities and ITS Departments in compliance with the Document Retention Schedule.

F. Litigation Holds

1. Due to ongoing or anticipated litigation, certain Documents may need to be retained beyond their normal destruction dates. General CounselLegal Affairs shall notify the Facilities or ITS Departments of any such Documents that need to be retained, and the Facilities or ITS Departments shall work with the appropriate departments to ensure that such Documents are not destroyed until released by the Legal Affairs Department General Counsel.

G. Confidential Document Management

1. CalOptima Health shall protect all confidential documents from unauthorized Disclosure in accordance with the Health Insurance Portability and Accountability Act (HIPAA), federal and state laws, and applicable CalOptima Health policies.

IV. ATTACHMENT(S)

A. CalOptima Health Document Retention Schedule

V. REFERENCE(S)

A. California Evidence Code, §1157

For 20240801 BOD Review Only

1 B. California Government Code, §§6250 through 6276.48
2 C. California Health and Safety Code, §1370
3 D. California Public Records Act
4 E. California Welfare and Institutions Code, §14100.2 and 14087.58(b) 14100.3
5 E.F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for
6 Medicare Advantage
7 F.G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
8 G.H. CalOptima Health PACE Program Agreement
9 H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the
10 Department of Health Care Services (DHCS) for Cal MediConnect
11 I. Health Insurance Portability and Accountability Act, as amended 2013
12 J. Title 42, Code of Federal Regulations, §§431.300 and 432.300 et seq.
13 K.A. California Welfare and Institutions Code, §14100.2 and 14087.58(b) 14100.3
14
15 **VI. REGULATORY AGENCY APPROVAL(S)**
16
17 None to Date
18
19 **VII. BOARD ACTION(S)**
20
21 03/01/12: Regular Meeting of the CalOptima Board of Directors
22 04/07/98: Regular Meeting of the CalOptima Board of Directors

Date	**Meeting**
04/07/1998	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Board of Directors

23
24 **VIII. REVIEW/REVISION HISTORY**
25

Action	**Date**	**Policy**	**Policy Title**	**Program(s)**
Effective	04/07/1998	GA.3201	Records Management Policy and Procedure	Administrative
Revised	02/01/2011	GA.3201	Document Management Program Policy	Administrative
Revised	08/01/2018	GA.3201	Document Management Program	Administrative
Revised	08/01/2024	GA.3201	Document Management Program	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
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Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Document(s)	A piece of written, printed, or electronic matter that provides information or evidence or that serves as an official record.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by ~~Cal Optima~~CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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For 20240801 BOD Review Only

Policy:	GA.3201
Title:	**Document Management Program**
Department:	Facilities
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/07/1998
Revised Date:	08/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

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3 This policy establishes guidelines for CalOptima Health's Document Management Program.
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5 **II. POLICY**
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7 A. CalOptima Health shall establish and maintain a Document Management Program to control the
8 organization, utilization, storage, retention, retrieval, and eventual disposal of all print and
9 electronic information created by CalOptima Health.
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11 B. CalOptima Health shall develop and maintain a Document Retention Schedule to cover all
12 Documents created, used, and received by CalOptima Health during the normal course of business.
13 The Document Retention Schedule shall adhere to state and federal laws, regulations and contracts,
14 as well as requirements by CalOptima Health and the agencies that oversee CalOptima Health.
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16 C. CalOptima Health shall protect all confidential documents including, but not limited to, Protected
17 Health Information (PHI), from unauthorized Disclosure in accordance with federal and state law.
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19 D. CalOptima Health shall destroy confidential Documents in accordance with this Policy, and only by
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22 E. CalOptima Health may destroy non-confidential Documents by recycling or deleting in accordance
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33 2. Provide and manage a contract with a vendor for the destruction of Documents slated for
34 destruction, in accordance with CalOptima Health's Document Retention Schedule;
35

3. Serve as a liaison with the off-site storage vendor and facilitate the transfer and retrieval of Documents with the off-site storage vendor; and

4. Serve as a liaison with the vendor for the destruction of Documents and facilitate the destruction of Documents with the vendor.

B. The Information Technology Services (ITS) Department shall be responsible for the electronic components of the Document Management Program, including:

1. Manage processes associated with electronic documents;

2. Maintain the Document Retention Schedule; and

3. Facilitate an annual audit of CalOptima Health's Document Retention Schedule with all identified departments.

C. Each CalOptima Health department shall be responsible for managing and maintaining its Documents in accordance with the Document Retention Schedule and the terms and conditions of this Policy.

1. A department director shall appoint and maintain a Document coordinator within the department to manage the department's Documents.

2. The Document coordinator shall:

a. Have overall responsibility for the department's Documents, the location of the Documents, and the contents of all boxes sent to off-site storage;

b. Select Documents for transfer to storage in accordance with the department's Document Retention Schedule and work with the Facilities Department to transfer the Documents to off-site storage;

c. Select Documents for destruction in accordance with the department's Document Retention Schedule and work with the Facilities and ITS Departments to coordinate destruction;

d. Obtain the appropriate authorization signatures for transferring or destroying Documents and return the Certificate of Destruction to the Facilities Department in a timely manner;

e. Assist his or her department staff with requesting the retrieval of Documents from off-site storage;

f. Participate in the review and revision of the Document Retention Schedule on an annual basis; and

g. Participate in the annual audit of CalOptima Health's Document Retention Schedule.

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1. Each department shall follow the Document Retention Schedule that shall cover all essential types of Documents created, used, and received in such department during the normal course of business.

For 20240801 BOD Review Only

2. The Document Retention Schedule shall adhere to state and federal laws, regulations and contracts, as well as requirements by CalOptima Health and the agencies that oversee CalOptima Health.

E. Document Destruction

1. Documents that are stored within a department for the duration of their retention period shall be disposed of by the department on at least an annual basis.

2. All confidential documents shall be destroyed by the bonded document destruction company contracted by CalOptima Health by shredding, or other secure means, as designated by CalOptima Health.

3. CalOptima Health staff shall be supplied with secured receptacles for document shredding.

4. All non-confidential Documents shall be destroyed by recycling.

5. The Facilities and ITS Departments will issue forms documenting the destruction of all Documents by all departments by whichever manner is appropriate.

6. Destruction Documents shall be maintained by the Facilities and ITS Departments in compliance with the Document Retention Schedule.

F. Litigation Holds

1. Due to ongoing or anticipated litigation, certain Documents may need to be retained beyond their normal destruction dates. General Counsel shall notify the Facilities or ITS Departments of any such Documents that need to be retained, and the Facilities or ITS Departments shall work with the appropriate departments to ensure that such Documents are not destroyed until released by General Counsel.

G. Confidential Document Management

1. CalOptima Health shall protect all confidential documents from unauthorized Disclosure in accordance with the Health Insurance Portability and Accountability Act (HIPAA), federal and state laws, and applicable CalOptima Health policies.

IV. ATTACHMENT(S)

A. CalOptima Health Document Retention Schedule

V. REFERENCE(S)

A. California Evidence Code, §1157
B. California Government Code, §§6250 through 6276.48
C. California Health and Safety Code, §1370
D. California Public Records Act
E. California Welfare and Institutions Code, §14100.2 and 14087.58(b) 14100.3
F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement

For 20240801 BOD Review Only

I. Health Insurance Portability and Accountability Act, as amended 2013
J. Title 42, Code of Federal Regulations, §§431.300 and 432.300 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/07/1998	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/07/1998	GA.3201	Records Management Policy and Procedure	Administrative
Revised	02/01/2011	GA.3201	Document Management Program Policy	Administrative
Revised	08/01/2018	GA.3201	Document Management Program	Administrative
Revised	08/01/2024	GA.3201	Document Management Program	Administrative

For 20240801 BOD Review Only

1 **IX. GLOSSARY**

2

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Document(s)	A piece of written, printed, or electronic matter that provides information or evidence or that serves as an official record.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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For 20240801 BOD Review Only

CalOptima Health Document Retention Schedule

Revised August 2024

This document retention schedule is written with general titles and descriptions rather than identifying specific individual documents or files. A document, regardless of format, with content and function that is substantially the same as the document described in this schedule should be considered covered by that series. The schedule indicates the length of time the records must be retained before disposal. These retention requirements are mandatory to reduce the costs of storage and maintenance while also ensuring that administrative, fiscal, regulatory, legal, and other recordkeeping responsibilities are met.

Documents, including copies held for convenience or reference, must be disposed of as directed herein at the end of the retention period. A full justification for any request to extend the retention period for a specific set of records must be given, in writing, to Information Technology Services, Records & Information.

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 0100	Advisory Committees	Records of the proceedings and minutes of advisory committees - those whose decisions help determine the course of organizational operations. Examples of committees include the Executive Committee (Chiefs and Executive staff), Finance and Audit, Member Advisory, Provider Advisory, Quality Assurance, and Investment Advisory.	Supporting Department	P	Historical Value			Archive
	Reporting - Elder / Child Abuse or Ombudsman	Records related to elder abuse or ombudsman reporting including notes, required forms or other supporting documentation.	All	Until Regulatory Audit, but not less than 3 years unless notified by DHCS to retain longer	WIC 10851(a)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 1200	Information / Media - Employee	Records related to employee specific communications that are not benefits related. May include announcements, instructions, newsletters, event flyers, etc.	Authoring Department	CY + 2	GOV 26202			Shred/Delete
	Training Materials - Regulatory	Records documenting the content of training provided to employees to meet regulatory requirements. May include audio or video recordings or published materials in	Authoring Department	REV or retired + 6	Gov. Contracts; 45 CFR 164.316 (b)(2)(i)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Training Materials - Other	Records documenting the content of training, other than regulatory related content, provided to employees. May include audio or	Authoring Department	REV or retired + 2	GOV 26202; SOS A-2; Best Practice			Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Regulatory Analysis & Implementation	Records related to the analysis of new regulatory requirements, its impact on internal business departments, planning, implementation, and validation of	Business Integration / Program Implementation	REV	Historical Value; Best Practice			Shred/Delete
	Maintenance and Transportation	Records related to the request and coordination of long term and/or long distance travel.	Case Management	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Whole Child Model Eligibility workflow	Records transmitted to and from California Child Services and Providers.	Case Management	Until Regulatory Audit, but not less than 10	Gov. Contracts; (ref. APL 21-005)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Claims	Records documenting the receipt and payment of provider claims for member services. May include claim forms, medical records, invoices, etc.	Claims	Until Regulatory Audit, but not less than 10 years	Gov. Contracts; 42 CFR 422.504 (d)(2); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Provider Dispute Resolutions (PDRs)	Records documenting the first level of provider dispute/appeal related to claim payment and/or denial. Includes the dispute/appeal, acknowledgement and resolution	Claims	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii); HSC 1367(h)(1)-(2);	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Provider Refund	Records related to the review of possible recoveries from providers and the determination and calculation of any refunds. Includes the original and refund check and	Claims / Finance / Office of Compliance	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504(d)(1)(i) and (d)(2)(ix); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 0500	Board of Directors	Records of the proceedings and actions of the Board of Directors. Includes meeting agendas, submittal packets (COBAR) and written minutes. Also includes	Clerk of the Board	P	Historical Value			Archive
ADM 2600	Recordings of Public Meetings - Board of Directors	Audio or video recordings of the Board of Directors public meetings.	Clerk of the Board	CR + 2 with approval of minutes	GOV 54953.5(b); GOV 26202; Best Practice			Delete
ADM 2300	Public Records Act Requests	Records related to requests for information under the Public Records Act. Includes the original request, internal correspondence,	Clerk of the Board / Information Technology Services	CY + 7	GOV 26202; Best Practice			Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 3500	Trademark and Copyright	Records related to the trademark and copyright of CalOptima Health.	Communications	P	Historical Value			Archive
	Information / Media - Public	Records related to community outreach and program activities. Records are generally intended to introduce, inform, educate or otherwise provide information regarding CalOptima Health programs and services to the public	Communications / Community Relations / Public Affairs	P	Historical Value			Archive
	Events - Hosted	Records related to community events hosted by the organization. Includes attendance sheets, event flyers, directories, financial /	Community Relations	P	Historical Value			Archive
	Events - Sponsored	Records related to CalOptima Health's involvement in a community event sponsored by the organization. Includes attendance	Community Relations	Until Regulatory Audit, but not less than 2 years	GOV 26202			Shred/Delete
	Contracts - Provider (including Health Networks)	The binding agreement to provide healthcare services to members. May include the original contract or agreement including delegation agreements, all changes, Business	Contracting	Termination of Contract or Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(2)(v); Best Practice regarding	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Selection Forms	Response from enrolled members indicating their selected provider and / or network.	Customer Service	CL + 7	Gov. Contracts; GOV 26202; Best Practice for Audit Purposes	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Member Enrollment	Records documenting a member's enrollment into one or more programs. May include application and supporting documentation such as their beneficiary (e.g.,	Customer Service / PACE	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504(d)(2); 42 CFR 438.3(h); 42 CFR 438.604	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Member Reimbursement	Records related to the review and resolution of member requests for reimbursement for out-of-pocket expenses for services already rendered. May include review for	Customer Service / Utilization Management	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 0200	Assessments - Contracted Entities	Records related to assessments of CalOptima Health conducted by contracted entities at the request of the organization. Includes correspondence, audit report and	Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.8(k) (1)(ii); 42 CFR 422.504 (d)(viii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 0900	Correspondence - Other	Routine correspondence issued from or received by a department that requires no further action and does not pertain to a member's	Department	CY + 2	SOS C-19; GOV 26202			Shred/Delete
ADM 1000	Desktop Procedures (DTP)	Documentation of internal processes created to ensure consistent methods and operations.	Department	Rev + 10	Gov. Contracts; 42 CFR 422.504(d)(2)(i)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504(d)(2)(i)	Shred/Delete
	Meeting Minutes	Written minutes of meetings, other than the Board of Directors or any Advisory Committee, that document key discussion and	Department	Until Regulatory Audit but not less than 10	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 2200	Project Files	Records related to projects designed to achieve a defined business objective and normally contained by content or purpose. May include correspondence,	Department	CL + 10	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 2400	Recordings of Internal Meetings	Audio or video recordings of internal meetings between CalOptima Health employees as necessary and approved.	Department	Until after minutes are written and approved but not less than 90 days or more than 120 days, if the	GOV 26206.7; Best Practice			Delete
ADM 3000	Reports and Statistics	Reports and statistical data maintained to establish trends or assist with business planning. Records series may include	Department	Last entry + 10	SOS C-19; Best Practice for informed trending			Shred/Delete
ADM 3100	Reviews - Internal	Records related to periodic, internal reviews conducted to verify or improve internal processes,	Department	CY + 10	SOS C-17; Best Practice			Shred/Delete
	Events - General	Records related to community events attended by CalOptima Health employees. These are distinguished by not being hosted by CalOptima Health or receiving financial contribution, e.g.	Department	Until Regulatory Audit, but not less than 2 years	GOV 26202			Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Correspondence - Members	Records documenting correspondence to and from members. May include requests for access to or to obtain a copy of the member designated record set (DRS). May also include requests to amend protected health information (PHI), accounting of disclosures, health information	Department	Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Quality Reviews - Internal	Records related to the review of work performed by CalOptima Health employees to ensure quality.	Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Personnel Files - Interns	Records related to qualifications and scope of work within a training program for interns. Includes documentation of efforts to meet requirements.	Department	T + 10	42 CFR 438.3(h); 42 CFR 422.504(d)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Personnel Files - Supervisor file	Supervisor records documenting an employee's work performance from one evaluation to the next. Relevant information must be	Department	Completion of annual evaluation + 2	GOV 26202; SOS C-21			Shred/Delete
	Communications - Federal / CMS	Records of communications to / from Federal agencies including the Centers for Medicaid & Medicare Services. Includes further regulatory memos issued by	Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3(h); Best Practice for audit/investigation protection			Shred/Delete
	Communications - State / DHCS	Records of communications to / from State agencies including the Department of Health Care Services. Includes further regulatory memos issued by Regulatory Affairs and Compliance (RAC). May include Operating Instructions Letters (OILs) and other formally issued plans and guidance.	Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3 (h); Best Practice for compliance cross-checks & demonstration, for audit and investigation purposes	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Vendor Oversight	Records related to the regular oversight of vendors to ensure they are meeting the terms of their agreement.	Department /Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d)(2)(v); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 0600	CalOptima Health - Creation and Establishment	Records related to the formation of the Orange County Health Authority (CalOPTIMA) and the information created to maintain organizational structure such as	Executive Office	P	SOS C-22; Historical Value	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Archive
ADM 2500	Recordings of Public Meetings	Audio or video recordings of a public body, other than the Board of Directors, subject to the Brown Act.	Executive Office	Until after minutes are written and approved but not	GOV 54953.5(b); Best Practice			Delete
	Building Access	Records of access to the CalOptima Health or PACE facilities. Includes badge swipe system records, sign-in sheets, employee or temporary	Facilities	C + 3	CCP 338; GOV 26202			Shred/Delete
ADM 0400	Business Continuity Plan	Records related to the creation, testing and, if needed, implementation of the business continuity plan, which is designed to ensure the organization can	Facilities	Rev + 10	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 1900	Maintenance - Property	Records related to the maintenance, repair and inventory of equipment or property.	Facilities	End of lease or ownership + 10	Gov. Contracts 42 CFR 422.504 (d)(2)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3200	Space Planning	Records related to planning and design of building offices and meeting spaces. Includes architectural drawings and designs,	Facilities	Duration of Building Ownership	Best Practice			Archive
ADM 3600	Video Surveillance / Monitoring	Recordings of routine video monitoring designed to record regular and ongoing operations such as building security systems. Excludes common areas such as the	Facilities	1 year with written consent from Legal Dept.	GOV 53160(a)			Delete
	Accident/Incident Reports	Documentation of employee accident / incident with or without injury.	Facilities	T + 30	29 CFR 1910.1020(d) (1) (OSHA requirement)	RECOMMEND DELETE THIS ROW; 29 CFR 1910.1020 applies to injuries caused by exposure to toxic substances (see Row 58). Normal employee accidents is covered in Row 60 below.		Shred/Delete
	Emergency Action and Fire Prevention Plans	Plans for evacuation of the facility in cases of emergency and other fire prevention plans. May include fire drill action plans, warden	Facilities	Rev	29 CFR 1910.38-.39; 8 CCR 3220			Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Fire Extinguisher Records	Records related to the annual inspection and maintenance of fire extinguishers.	Facilities	Last entry + 2	29 CFR 1910.157 (e)(3); 8 CCR 6151(e)(3); GOV 26202			Shred/Delete
	Fire Orders	Orders issued by the Fire Marshal to correct compliance with the fire	Facilities	CL + 2	SOS C-32; GOV 26202			Shred/Delete
	Fire Orders - PACE	Orders issued by the Fire Marshal to correct compliance with the fire	Facilities	Until Regulatory audit, + 2	GOV 26202; Gov. Contracts			Shred/Delete
	First Aid Records	Records documenting one-time first aid treatment and subsequent observation of minor illnesses and injuries sustained onsite. Related to treatment provided by a non-	Facilities	CY + 5	29 CFR 1910.1020(d) (1)(i)(B)			Shred/Delete
	Hazardous Exposure	Records related to employee exposure to toxic substances or harmful physical agents.	Facilities	T + 30	29 CFR 1910.1020(d)(1)(ii); 8 CCR			Shred/Delete
	Hazardous Waste Records	Records related to the management of hazardous or medical waste. Includes registration, reporting, training and	Facilities	CY + 3	22 CCR 66262.40; HSC 117945(a)(2); HSC			Shred/Delete
	Incident / Accident Report	Records related to the reporting and documentation of employee	Facilities	CY + 5	29 CFR 1904.33; 8 CCR 14300.33			Shred/Delete
LEG 0400	Threat or Emergency Matters	Records related to receipt and response to threatening or emergency situations. May include correspondence, restraining orders	Facilities / Legal Affairs	CL + 1	GOV 68152(c); Best Practice; only Superior Court charged	CL + 2	Best Practice; Legal recommendation	Shred/Delete
	Material Safety Data Sheets	MSDS (SDS) safety data sheets issued by manufacturers.	Facilities / PACE	T + 30	29 CFR 1910.1020(d)			Shred/Delete
ADM 0300	Bids - not accepted	Records of bid packets received where a contract is not awarded. May include the proposal, request for quotation (RFQ), Request for Proposal (RFP) or Request for	Finance	CL + 4	CCP 337; BPC 17208; GOV 26202			Shred/Delete
ADM 0700	Contracts and Agreements	The binding agreement to provide or receive goods or services. May include the original contract or agreement, all change orders, Business Associate Agreement (BAA), bidding exception forms,	Finance	Termination of Contract or Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504 (d)(2)(v); CCP 337	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 1400	Insurance, Liability - Claims	Records related to denial or payment of claims made against liability insurance policies.	Finance	CL + 10	SOS C-24, 29 CFR 1904.33; CCP 337.15; 8 CCR 15400.2; 8 CCR 14300.33; 8 CCR 10102; Best Practice for Gov.	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2); SOS C-24, 29 CFR 1904.33; CCP 337.15; 8 CCR 15400.2; 8 CCR 14300.33; 8 CCR	Shred/Delete
ADM 1700	Lease Agreements	Records related to rental agreements, capital leases, operations lease/purchase agreements or any other similar agreement and the amendments	Finance	CL + 10	CCP 337	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Archive
	Licenses - Property	Records related to property licenses such as our office buildings and PACE location.	Finance	P	Historical Value			Archive
ADM 1800	Licenses - Capital	Records related to capital expenditure licenses including those related to software or other information technology systems.	Finance	Expiration + 10	Best Practice; 42 CFR 422.504(d)(2)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Assets - Property	Records related to the purchase or sale of capital assets such as real estate, including analysis and recommendations from CalOptima	Finance	P	42 CFR 422.504 (d)(1)(i)-(d)(2); CCP 337.15; Best Practice			Archive
	Budget - Approved	Official budget of the organization as submitted to and approved by the Board of Directors. May also be part of the packet and minutes of	Finance	P	Historical Value; Best Practice			Archive
	Coding Analysis	Records documenting medical chart coding analysis including notation of questions or discrepancies that may lead to a denial of claims.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d)(2); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Provider Incentive	Records related to pay-for-value programs and other quality related incentives.	Finance	Until Regulatory Audit, but not less than 10 years	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 1500	Insurance, Liability - Policies and	Documented agreement stating the obligations and responsibilities of	Finance	P	Best Practice; SOS C-24			Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Accounting Record	Records related to or involved in the preparation of financial statements or records relevant to audits and financial reviews. May include, when not related to tax, canceled checks, reconciled bank	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)-(d)(2); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Base Data	Records related to Medi-Cal rate development such as reported encounter data, cost and utilization data.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d)(1)(vi) ; 42 CFR 438.5(c)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Budget - Supporting information	Records supporting budgetary expenses. May include approved budget, expense reports.	Finance	Until Regulatory Audit, but not less than 10	Best Practice for timely audit support	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Capitation	Health network payment reconciliation and financial reports.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504 (d); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Financial Statements	Final audited financial statements maintained to demonstrate the ability to bear the risk of potential financial losses or to show services performed or determinations of	Finance	P	42 CFR 422.504 (d)(2)(iii); 42 CFR 438.3(h); Best Practice; Historical Value			Archive
	Health Network Solvency	Records related to the review of health network financial reports and regulatory filings to gauge their ability to pay claims.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504(d)(1)(iii); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Ledgers	Ledgers demonstrating the recordkeeping system of the organization's financial data with debit and credit account records validated by a trial balance. The	Finance	P	Best Practice			Archive
	Ledgers - supporting documentation	Records supporting the general revenue and expense accounting (financial transactions) for the organization.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d)(1)-(2); Best Practice for audit support	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Medical Loss Ratio (MLR) Reports - CalOptima Health	Reports generally representing a percentage of revenue used for patient care rather than for items such as administrative expenses or profit.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.8(k); 42 CFR 422.504(d)(1)-(2)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Medical Loss Ratio (MLR) Reports - Health Networks	Reports generally representing a percentage of revenue used for patient care rather than for items such as administrative expenses or profit.	Finance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.8(k); 42 CFR 422.504(d)(1)-(2)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Payroll	Records documenting salary as well as benefits, taxes and other withholdings of employees.	Finance	T + 7	29 CFR 516.5(a); 42 CFR 422.504 (d)(2)(viii); 42 USC 20000e-5(e)(3); Best Practice for Fair	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Tax Records	Records related to payment of taxes. May include tax returns (premiums, sales tax, Managed Care Organization tax, Foundation 990), and canceled checks demonstrating payment.	Finance	Until Regulatory Audit, but not less than 10	18 CCR 19141.6 (h)(5)(i) (1)(A); 42 CFR 422.504 (d)(2)(iii); 42 CFR 438.8(k)(1)(vi); Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2); 18 CCR 19141.6 (h)(5)(i) (1)(A); 42 CFR 422.504	Shred/Delete
	Encounters	Data submitted by our contracted health networks in support of services rendered to members. Submissions are based on the 837 5010 or XML formats, i.e., "universe	Finance / Audit & Oversight	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Assets - Non-Property	Records related to the funding, purchase, acquisition and disposal of a non-property asset.	Finance / Information Technology Services / Facilities	Disposal of Asset + 10	Gov. Contracts; 42 CFR 422.504 (d)(2)(iv); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Constituent Case Work	Records related to addressing and processing member concerns initiated by elected officials or their staff.	Government Affairs	CL + 2	GOV 26202; Best Practice in keeping with Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Legislative Advocacy and Engagement	Records related to the tracking, monitoring, and possible advocacy of legislation that affects the mission of CalOptima Health. Includes community engagement,	Government Affairs	CL + 2	GOV 26202; Best Practice for historical, trends, and benchmarking			Shred/Delete

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	Regulatory Advocacy and Engagement	Records related to the tracking, monitoring, and possible advocacy of regulations that affects the mission of CalOptima Health. Includes community engagement,	Government Affairs	CL but no more than 2 years	GOV 26202; Best Practice for historical, trends, and benchmarking			Shred/Delete
	Grievances and Appeals	Records related to member or provider grievances and any appeals to decisions rendered. Includes initial complaint, correspondence including the	Grievance and Appeals Resolution Services / PACE	Until Regulatory Audit, but not less than Closed + 10	Gov. Contracts; 42 CFR 438.3(u); 42 CFR 438.416	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2000	Organizational Charts	Records of the organizational structure at any period of time.	Human Resources	P	Historical Value			Archive
	Application and Selection Records - not hired	Records related to the application and selection process of persons not hired. May include application, interview notes, test results, background check and drug screening results, etc. (Records	Human Resources	CL + 2	29 CFR 1627.3(b)(1)(i); 29 CFR 1602.31; 29 CFR 1602.30; GOV 12946; 2 CCR 11013; SOS			Shred/Delete
	Benefits - Claims	Records documenting employee claims to benefits including the type of claim and benefit and / or payment received.	Human Resources	T + 6	Best Practice for potential CalPERS audit of compensation	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Benefits - Leave ~~file~~	Records related to the benefits afforded each employee as part of a leave of absence. May include Family Medical Leave (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL),	Human Resources	T + 3	29 CFR 825.500 (b), 29 CFR 1910.1020(d)(1); Best Practice for potential CalPERS audit of	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Benefits - Plans	Records documenting employee benefits plans including but not limited to health, dental, disability, education, life, vision, dependent care, employee assistance, COBRA,	Human Resources	P	29 USC 1027; 29 USC 1059; 29 CFR 1627.3; SOS C-20			Archive
	Employment Eligibility Verification (I-9 Form) - hired	Employees' completed Employment Eligibility Verification form (I-9).	Human Resources	T + 3	9 CFR 274a.2(b)(2)(i)(A)	Employment start date + 3 years or T + 1 year, whichever is later recommend removing "hired" distinction. See below.	8 CFR 274a.2(b)(2)(i)(A)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Employment Eligibility Verification (I-9 Form) - not hired	Interested persons', not hired by CalOptima Health, completed Employment Eligibility Verification form (I-9).	Human Resources	CY + 3	8 CFR 274a.2(b)(2)(i)(A)	Recommend deleting. CalOptima should only obtain an I9 when someone is hired.		Shred/Delete
	Employee Handbook	Record of the policies, practices and benefits for CalOptima Health employees.	Human Resources	REV + 5	GOV 12965	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Equal Employment Opportunity (EEO)	Records related to compliance with the Equal Employment Opportunity Commission. May include survey responses, supplemental	Human Resources	CY + 3	29 CFR 1602.30			Shred/Delete
	Information / Media - Human Resources	Records related to communications from Human Resources to the workforce regarding benefits, open enrollment, training availability,	Human Resources	CY + 4	GOV 12960; Best Practice			Shred/Delete
	Job Descriptions	Records related to the creation, revision and finalization of job	Human Resources	REV + 2	GOV 26202; Best Practice			Shred/Delete
	Employee Exposure to Hazardous	Records relating to employee exposure to hazards such as toxic chemicals, high levels of noise,	Human Resources	T + 30	8 CCR 3204(d)	RECOMMEND DELETE THIS ROW; duplicative of Row 58.		Shred/Delete
	Medical Records - Employees	Records related to employee medical history, which is kept separate from the personnel file. May include pre-employment or	Human Resources	T + 5	8 CCR 10102, 14300.33(a)			Shred/Delete
	Pension / Retirement	Records related to eligibility and enrollment in retirement programs and information related to the associated benefits. Includes	Human Resources	T + 6	Best Practice for potential CalPERS audit of compensation			Shred/Delete
	Personnel Files - Human Resources	Records related to an employee's or resident's recruitment and retention. May include application/resume, background check results, conflict of interest (Form 700) (pre-online submittal process) pre-employment test results, training, acknowledgement	Human Resources	T + 4	GOV 12946; 29 CFR 516.5; 42 USC 20000e-5(e)(3)			Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Recruitment	Records related to the personnel recruitment process. May include the Request to Fill and internal correspondence.	Human Resources	CL + 3	29 CFR 1627.3(b)(1)(i); 29 CFR 1602.31; 29 CFR 1602.30; GOV 12946; 2 CCR 11013; SOS			Shred/Delete
	Wage Rate Tables	Record of the amount of base wage paid to employees per unit of time. Data is retained to support calculated basis for retirement.	Human Resources	CY + 6 or P if attached to an approved implementing policy	29 CFR 516.6(a)(2); 2 CCR 570.5(a)(7); SOS C-19; Best Practice for potential			Shred/Delete
ADM 1600	Insurance - Unemployment	Records documenting unemployment compensation claims as well as insurance premiums paid. May include employee status, claim details, pertinent correspondence, and materials related to unemployment compensation and insurance	Human Resources	CL + 4	26 USC 3301-311; 26 CFR 31.6001-1(e)(2); 22 CCR 1085-2(c)			Shred/Delete
	Workers' Compensation	Records related to employee workers' compensation. Retention is based on the end of year in which	Human Resources	T + 4	GOV 12946; 29 CFR 516.5; 42 USC 20000e-			Shred/Delete
	Workers' Compensation - Hazardous Exposure	Records related to employee workers' compensation for exposure to toxic substances or other harmful physical agents.	Human Resources	T + 30	29 CFR 1910.1020(d)(ii) 8 CCR 3204(d)(1)(B)			Shred/Delete
	Work Schedules and Compensation	Records related to employees scheduled work days and hours and compensation received (salary and	Human Resources / Finance	FY + 4	29 CFR 516.2; 29 CFR 1627.3; CCP 338(d)			Shred/Delete
ADM 1100	Disaster Recovery Plan	Records related to the creation, testing and, if needed, implementation of the disaster recovery plan, which is designed to ensure the organization can return	Information Technology Services	Rev + 10	Gov. Contracts; 42 CFR 422.504(d)(2)(i)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 1300	Information Systems	Records related to the ownership and operation of financial, medical and other record keeping systems. May include documentation of system changes such as upgrades, coding, architecture,	Information Technology Services	Retired + 10	Gov. Contracts 42 CFR 422.504 (d)(2)(i)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2700	Records Disposition	Records documenting the eligible records destroyed and the	Information Technology Services	P	SOS C-23			Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
ADM 2800	Records Retention Schedule	The approved records retention schedule that provides legal authority for the disposition of	Information Technology Services	P	CCP 343; Best Practice to support			Archive
ADM 2900	Records Transfer List	The list of records transferred to an offsite location / vendor. Includes	Information Technology Services	Until destruction of all listed	Best Practice to support			Shred/Delete
	Telephone Recordings	Routine and regular recording of telephone communications to and from the organization.	Information Technology Services	100 days with written consent from legal	GOV 53160; GOV 26202.6; Best Practice			Delete
	Resource Guides and Program Manuals	Resources issued to assist providers with understanding the administrative processes related to providing health care services to members.	Issuing Department	REV + 6	Gov. Contracts; 42 CFR 438.3(h); 45 CFR 164.316 (b)(2)(i)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
LEG 0100	Legal Files	Records related to requests and responses to legal questions or concerns. May include Request for	Legal Affairs	CL + 1	Best Practice			Shred/Delete
LEG 0200	Litigation / Government Claims	Records related to litigation or claims by or against CalOptima Health. May include government claims, pleadings, transcripts, notices, or depositions.	Legal Affairs	CL + 10	GOV 68152(a)(1); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
LEG 0300	Subpoenas	Records related to the receipt and fulfillment of subpoenas (requests for records by an authorized third party). Includes original request, Authorization for Release of	Legal Affairs / Information Services	CL + 2	GOV 26202; Best Practice			Shred/Delete
	Multipurpose Senior Services Program (MSSP)	Records related to the implementation of the MSSP including participant enrollment and care management information.	Long Term Services Support	Until audit resolution, but not less than 10	MSSP Contract with California Department of Aging; Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	MSSP Contract with California Department of Aging; Government Contracts; 42 CFR 438.3(h), (u); 42 CFR	Shred/Delete
	Social Media	Posts and stories created for CalOptima Health social media such as the official website, Instagram, Facebook, X, LinkedIn, or YouTube.	Marketing & Communications	P	Best Practice			Archive
	Care Management	Records related to member care management. May include health risk assessments (HRAs) or other assessment tool, clinical screenings, care plans including discharge planning, PHI disclosure forms,	Medical Affairs	Regulatory Audit, but not less than 10	42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Interdisciplinary Care Team Review	Records related to the interdisciplinary review of member health information to improve services and benefits. Includes medication review, provider	Medical Affairs	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Medical Records	A written account of a member's examination and treatment that includes medical history and complaints, provider's findings, results of diagnostic tests and	Medical Affairs	Not less than 10 from CL of contract, from CL of regulatory audit, or from	42 CFR 438.3(u); WIC 14124.1; 28 CCR 1300.67.8(b)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Quality of Care	Records related to the quality, appropriateness and timeliness of services performed as well as facilities utilized.	Medical Affairs	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Provider Coordination	Records related to the internal coordination of provider services. May include distributed material review and approval, template	Network Management	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(e)(2); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2100	Policies and Procedures	Records of the policies and procedures approved and implemented by the organization.	Office of Compliance	P	Historical Value			Archive
	Audit Reports - Regulatory Agencies	Records related to audits of CalOptima Health conducted by regulatory agencies. May include audit report, Corrective Action Plans (CAPs) and correspondence.	Office of Compliance	CL + 10	42 CFR 438.3(h); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Contracts and Agreements - government oversight	Contracts with and related correspondence to / from our government oversight bodies including CMS, DHCS, MSSP and PACE.	Office of Compliance	Termination of Contract or Regulatory Audit, + 10	Gov. Contracts; Best Practice for audit readiness; 42 CFR 422.504 (d)(2)(v)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Fraud Referral Cases	Records related to the investigation of suspected fraud.	Office of Compliance	Until Regulatory Audit, + 10	Gov. Contracts; 42 CFR 422.504 (d)(2); 42 CFR 438.8(k) (1)(iii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Investigations - HIPAA	Records related to investigations into suspected HIPAA violations. May include request from member or other to investigate, regulator reports and breach files.	Office of Compliance	CL + 10	Gov. Contracts; 45 CFR 164.414 (b); 45 CFR 164.530(j)(2); 42 CFR	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Investigations - Non-Compliance (NCI)	Records related to investigations into suspected non-compliance. May include request to investigate and findings.	Office of Compliance	CL + 10	Gov. Contracts; 42 CFR 422.504(e)(1)(2); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Licenses - Operational	Records related to operational licenses or certificates such as Knox-Keene, Clinical Laboratory Improvement Amendment (CLIA),	Office of Compliance	P	Best Practice; Historical Value			Archive
	Auditing/Monitoring Reports - Health Networks, FDRs, Pharmacies	Records related to audits performed by CalOptima Health of the organization's external health networks and First Tier, Downstream, and Related Entities	Office of Compliance / Originating Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii); 42 CFR 438.3(h); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Auditing/Monitoring reports - Internal	Records related to audits performed by Office of Compliance on internal departments in order to gauge compliance with laws, regulations and internal policies. Includes large audits and smaller,	Office of Compliance / Originating Department	CL + 10	42 CFR 438.3(h); Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Protected Health Information Requests	Records documenting a member's request for access to or a copy of their designated record set. Includes the request and response.	Office of Compliance / PACE	CL + 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii); (e)(1)(ii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Reporting - regulatory	Periodic and ad hoc reports of, for example, member and program utilization statistics often for program evaluation by state or federal agencies.	Office of Compliance / Reporting Department	CL + 10	Gov. Contracts 42 CFR 422.504(f); 42 CFR 438.3(h); Best Practice for quality improvement, internal	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Emergency Action and Fire Prevention Plans - PACE	Plans for evacuation of the facility in cases of emergency and other fire prevention plans. May include fire drill action plans, warden training and manual, and safety	PACE	Rev	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Fire Extinguisher Records - PACE	Records related to the annual inspection and maintenance of fire extinguishers.	PACE	Last entry + 2	Gov. Contracts; GOV 26202	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	First Aid Records - PACE	Records documenting one-time first aid treatment and subsequent observation of minor illnesses and injuries sustained onsite. Related to treatment provided by a non-	PACE	Until Regulatory audit, + 2	GOV 26202; Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Hazardous / Medical Waste Records - PACE	Records related to the management of hazardous or medical waste. Includes registration, reporting, training and tracking documentation.	PACE	Until Regulatory audit, but not less than 10	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Incident / Safety / Security Report - PACE	Records related to the reporting and documentation of employee related incidents or accidents.	PACE	Until Regulatory audit, but not less than 10	Gov. Contracts	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Drug Formulary	Records related to the review and approval of member drug options. Includes rationale, drug codes, indications of which are covered or not.	Pharmacy	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504(d)(1)(i)-(II); 42 CFR 438.3(h)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Prescription Drug Denial / Appeal	Records related to the request for, denial of and, as applicable, appeal for prescription drugs.	Pharmacy / PACE	Until Regulatory Audit, but not less than Closed + 10	Gov. Contracts; 42 CFR 422.504(d)(1)(ii); 42 CFR 438.3(h); Best Practice regarding controlled	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Member Incentive Programs (MIP)	Records related to the creation and implementation of the various incentive / rewards programs. Includes eligibility, program materials, rewards distribution, and	Population Health	CL + 2	GOV 26202	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Process Improvement - Workflows & Analysis	Records and resources related to process excellence initiatives including current and future state process flows, process playbooks, desktop procedures,	Process Excellence / Program Implementation	CY + 10	Gov. Contracts; Best Practice for trend analysis	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	In-Service	Records related to provider onboarding, orientation and annual training.	Provider Relations	CL + 2	GOV 26202; Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Provider Relations	Records related to establishing and maintaining a relationship with providers. Includes correspondence, add-change-term forms, meeting materials, newsletters, registration, provider	Provider Relations / Provider Data Management Services	T + 10	Gov. Contracts; 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii), (e)(2)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Report to the Community (RTC)	The official report made to the community stating the agency's assets and liability and providing an	Public Affairs	P	Historical Value; Best Practice			Archive
	Financial Participation with External Entities	Records related to financial participation for external entities, such as charitable organizations, in furtherance of CalOptima Health's purpose pursuant to CalOptima	Public Affairs	Until Regulatory Audit, but not less than 10	42 CFR 422.504 (d)(2); 42 CFR 438.3(h); Best Practice for audit support	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Quality Analytics	Records related to the analysis of current and historical data to predict trends, improve services and better manage resources in order to improve patient care.	Quality Analytics / Medical Affairs	Until Regulatory Audit, but not less than 10	Gov. Contracts; Best Practice for quality improvement and compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Accreditation	Records related to the accreditation process and subsequent improvements for each reaccreditation effort. May include survey~~s~~ results and responses.	Quality Improvement	CL + 10	42 CFR 438.3(h); Best Practice to accommodate the reaccreditation	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Credentialing	Records related to the credentialing and subsequent re-credentialing of physicians and providers. Includes applications, correspondence, supplemental information,	Quality Improvement	T + 10	Gov. Contracts; 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Facility Site Reviews	Records related to facility inspections and personnel interviews conducted on behalf of a regulatory body to determine if practices and systems on site meet	Quality Improvement	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii), (e)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Quality Improvement	Records related to the organization's continuous efforts to improve member services. Includes ad hoc reporting for purposes such as trend analysis, incident reports,	Quality Improvement / Medical Affairs	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 422.504 (d)(1)(ii)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition
	Delegation oversight	Records related to the review of delegated entities to ensure compliance with regulatory and contractual requirements as well as CalOptima Health policies and	Regulatory Affairs & Compliance	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3(h); 42 CFR 422.504 (d)(1)(ii), (e)	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Disenrollment Feedback Analysis	Records related to the review and analysis of member disenrollment feedback for the purpose of improving programs or outreach. Includes periodic data extractions,	Sales & Marketing	CL + 2	GOV 26062; Best Practice for trending	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3300	Steering Groups	Records of the proceedings and minutes of decision and oversight groups regardless of their supporting or reporting role. Examples include Audit & Oversight, Compliance, Data and Information Governance, Pharmacy	Sponsoring Department	CY + 10	Gov. Contracts; Best Practice for business continuity	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Education Programs	Records related to the acquisition, review and dissemination of education materials to members, providers and the public. Includes advertising/outreach, curricula,	Sponsoring Department	Until Regulatory Audit, but not less than 10 years	Gov. Contracts; Best Practice	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3400	Strategic Plan	Records related to the creation and any significant revision to the	Strategic Development	P	Historical Value			Archive
	Relationships and Initiatives	Records related to CalOptima Health's involvement in the community including attending meetings hosted by others, external collaborations, and participation in	Strategic Development	Until Regulatory Audit, but not less than 2 years	GOV 26202			Shred/Delete
	Foundation	Records related to the CalOptima Health 501(c)3 foundation. Includes establishment and closure	Strategic Development	P	Best Practice; Historical Value			Archive
	Grants	Records related to the application, award, implementation and conclusion of a grant. Includes records related to award and dispersal of grant funds. May	Strategic Development / Department Receiving Funding	Until Regulatory Audit, but not less than 10	Gov. Contracts 42 CFR 422.504 (d)(2)(ix); 42 CFR 438.3(h); Historical Value	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Program Files	Records related to the creation, implementation and closure of public facing programs. Includes, as applicable, contracts, mission/vision statements,	Strategic Development / Medical Affairs	Until Regulatory Audit, but not less than Closed + 10	Gov. Contracts; Historical Value	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Retention (proposed change)	Citation / Rationale (proposed change)	Final Disposition

Code

Administration (ADM)
Community (COM)
Financial (FIN)
Health and Safety (HAS)
Legal (LEG)
Members (MEM)
Operations (OPR)
Personnel (PER)
Providers (PRO)
Regulatory / Compliance (REG)

CalOptima Health Document Retention Schedule

Revised August 2024

This document retention schedule is written with general titles and descriptions rather than identifying specific individual documents or files. A document, regardless of format, with content and function that is substantially the same as the document described in this schedule should be considered covered by that series. The schedule indicates the length of time the records must be retained before disposal. These retention requirements are mandatory to reduce the costs of storage and maintenance while also ensuring that administrative, fiscal, regulatory, legal, and other recordkeeping responsibilities are met.

Documents, including copies held for convenience or reference, must be disposed of as directed herein at the end of the retention period. A full justification for any request to extend the retention period for a specific set of records must be given, in writing, to Information Technology Services, Records & Information.

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
ADM 0100	Advisory Committees	Records of the proceedings and minutes of advisory committees - those whose decisions help determine the course of organizational operations. Examples of committees include the Executive Committee (Chiefs and Executive staff), Finance and Audit, Member Advisory, Provider Advisory, Quality Assurance, and Investment Advisory.	Supporting Department	P	Historical Value	Archive
	Reporting - Elder / Child Abuse or Ombudsman	Records related to elder abuse or ombudsman reporting including notes, required forms or other supporting documentation.	All	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 1200	Information / Media - Employee	Records related to employee specific communications that are not benefits related. May include announcements, instructions, newsletters, event flyers, etc. Note: If the communication pertains to another records series such as a regulatory or project update, retain with that series.	Authoring Department	CY + 2	GOV 26202	Shred/Delete
	Training Materials - Regulatory	Records documenting the content of training provided to employees to meet regulatory requirements. May include audio or video recordings or published materials in any format.	Authoring Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Training Materials - Other	Records documenting the content of training, other than regulatory related content, provided to employees. May include audio or video recordings or published materials in any format.	Authoring Department	REV or retired + 2	GOV 26202; SOS A-2; Best Practice	Shred/Delete
	Regulatory Analysis & Implementation	Records related to the analysis of new regulatory requirements, its impact on internal business departments, planning, implementation, and validation of new initiatives / programs, and documentation of transition to maintenance of business.	Business Integration / Program Implementation	REV	Historical Value; Best Practice	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Maintenance and Transportation	Records related to the request and coordination of long term and/or long distance travel.	Case Management	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Whole Child Model Eligibility workflow	Records transmitted to and from California Child Services and Providers.	Case Management	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Claims	Records documenting the receipt and payment of provider claims for member services. May include claim forms, medical records, invoices, etc.	Claims	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Provider Dispute Resolutions (PDRs)	Records documenting the first level of provider dispute/appeal related to claim payment and/or denial. Includes the dispute/appeal, acknowledgement and resolution letters.	Claims	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Provider Refund	Records related to the review of possible recoveries from providers and the determination and calculation of any refunds. Includes the original and refund check and backup documentation.	Claims / Finance / Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 0500	Board of Directors	Records of the proceedings and actions of the Board of Directors. Includes meeting agendas, submittal packets (COBAR) and written minutes. Also includes correspondence to and from the Board members, bylaws and member rosters.	Clerk of the Board	P	Historical Value	Archive
ADM 2600	Recordings of Public Meetings - Board of Directors	Audio or video recordings of the Board of Directors public meetings.	Clerk of the Board	CR + 2 with approval of minutes	GOV 54953.5(b); GOV 26202**;** Best Practice	Delete
ADM 2300	Public Records Act Requests	Records related to requests for information under the Public Records Act. Includes the original request, internal correspondence, and detailed description or copies of the information provided.	Clerk of the Board / Information Technology Services	CY + 7	GOV 26202; Best Practice	Shred/Delete
ADM 3500	Trademark and Copyright	Records related to the trademark and copyright of CalOptima Health.	Communications	P	Historical Value	Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Information / Media - Public	Records related to community outreach and program activities. Records are generally intended to introduce, inform, educate or otherwise provide information regarding CalOptima Health programs and services to the public and members to encourage enrollment, retention or support. May include endorsements, marketing materials, newsletters, press releases, newspaper articles, etc.	Communications / Community Relations / Public Affairs	P	Historical Value	Archive
	Events - Hosted	Records related to community events hosted by the organization. Includes attendance sheets, event flyers, directories, financial / transaction information, invitation / distribution lists.	Community Relations	P	Historical Value	Archive
	Events - Sponsored	Records related to CalOptima Health's involvement in a community event sponsored by the organization. Includes attendance sheets, event flyers, directories, financial / transaction information, invitation / distribution lists.	Community Relations	Until Regulatory Audit, but not less than 2 years	GOV 26202	Shred/Delete
	Contracts - Provider (including Health Networks)	The binding agreement to provide healthcare services to members. May include the original contract or agreement including delegation agreements, all changes, Business Associate Agreement (BAA), correspondence, and any amendments.	Contracting	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Selection Forms	Response from enrolled members indicating their selected provider and / or network.	Customer Service	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Member Enrollment	Records documenting a member's enrollment into one or more programs. May include application and supporting documentation such as their beneficiary (e.g., Qualified Medicare Beneficiary form). May also include disenrollment documentation as applicable.	Customer Service / PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Member Reimbursement	Records related to the review and resolution of member requests for reimbursement for out-of-pocket expenses for services already rendered. May include review for medical necessity, copies of checks cut and proof of mailing.	Customer Service / Utilization Management	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 0200	Assessments - Contracted Entities	Records related to assessments of CalOptima Health conducted by contracted entities at the request of the organization. Includes correspondence, audit report and corrective actions as appropriate.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
ADM 0900	Correspondence - Other	Routine correspondence issued from or received by a department that requires no further action and does not pertain to a member's health or eligibility or is not otherwise related to a CalOptima Health LOB.	Department	CY + 2	SOS C-19; GOV 26202	Shred/Delete
ADM 1000	Desktop Procedures (DTP)	Documentation of internal processes created to ensure consistent methods and operations.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504(d)(2)(i)	Shred/Delete
	Meeting Minutes	Written minutes of meetings, other than the Board of Directors or any Advisory Committee, that document key discussion and decisions made.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 2200	Project Files	Records related to projects designed to achieve a defined business objective and normally contained by content or purpose. May include correspondence, milestones, scope of work or any other information relevant to decision making, approvals, purpose and completion.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 2400	Recordings of Internal Meetings	Audio or video recordings of internal meetings between CalOptima Health employees as necessary and approved.	Department	Until after minutes are written and approved but not less than 90 days or more than 120 days, if the recording is a duplicate of another retained record of the meeting.	GOV 26206.7; Best Practice	Delete
ADM 3000	Reports and Statistics	Reports and statistical data maintained to establish trends or assist with business planning. Records series may include correspondence, membership numbers, services rendered, etc.	Department	Last entry + 10	SOS C-19; Best Practice for informed trending	Shred/Delete
ADM 3100	Reviews - Internal	Records related to periodic, internal reviews conducted to verify or improve internal processes, evaluated risk or inform decision making.	Department	CY + 10	SOS C-17; Best Practice	Shred/Delete
	Events - General	Records related to community events attended by CalOptima Health employees. These are distinguished by not being hosted by CalOptima Health or receiving financial contribution, e.g. sponsorship. Includes attendance information and any action items for CalOptima Health noted.	Department	Until Regulatory Audit, but not less than 2 years	GOV 26202	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Correspondence - Members	Records documenting correspondence to and from members. May include requests for access to or to obtain a copy of the member designated record set (DRS). May also include requests to amend protected health information (PHI), accounting of disclosures, health information forms (HIF-METs), requests for restrictions to PHI, restrictions on communications such as text messaging, coordination of benefits (COB), (dis)enrollment & satisfaction surveys, assignment of power of attorney or beneficiary, etc.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Quality Reviews - Internal	Records related to the review of work performed by CalOptima Health employees to ensure quality.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Personnel Files - Interns	Records related to qualifications and scope of work within a training program for interns. Includes documentation of efforts to meet requirements.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Personnel Files - Supervisor file	Supervisor records documenting an employee's work performance from one evaluation to the next. Relevant information must be documented within the annual evaluation.	Department	Completion of annual evaluation + 2	GOV 26202; SOS C-21	Shred/Delete
	Communications - Federal / CMS	Records of communications to / from Federal agencies including the Centers for Medicaid & Medicare Services. Includes further regulatory memos issued by Regulatory Affairs and Compliance (RAC). May include HPMS memos and other formally issued plans and guidance.	Department	Until Regulatory Audit, but not less than 10	Gov. Contracts; 42 CFR 438.3(h); Best Practice for audit/investigation protection	Shred/Delete
	Communications - State / DHCS	Records of communications to / from State agencies including the Department of Health Care Services. Includes further regulatory memos issued by Regulatory Affairs and Compliance (RAC). May include Operating Instructions Letters (OILs) and other formally issued plans and guidance.	Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
	Vendor Oversight	Records related to the regular oversight of vendors to ensure they are meeting the terms of their agreement.	Department /Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
ADM 0600	CalOptima Health - Creation and Establishment	Records related to the formation of the Orange County Health Authority (CalOPTIMA) and the information created to maintain organizational structure such as name, purpose/mission, Board of Directors. Includes the Articles of Incorporation, and the organization's bylaws.	Executive Office	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Archive
ADM 2500	Recordings of Public Meetings	Audio or video recordings of a public body, other than the Board of Directors, subject to the Brown Act.	Executive Office	Until after minutes are written and approved but not less than 30 days or more than 120 days	GOV 54953.5(b); Best Practice	Delete
	Building Access	Records of access to the CalOptima Health or PACE facilities. Includes badge swipe system records, sign-in sheets, employee or temporary badge assignments and any other records of access to the physical building(s).	Facilities	C + 3	CCP 338; GOV 26202	Shred/Delete
ADM 0400	Business Continuity Plan	Records related to the creation, testing and, if needed, implementation of the business continuity plan, which is designed to ensure the organization can continue operations during a disaster.	Facilities	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c)	Shred/Delete
ADM 1900	Maintenance - Property	Records related to the maintenance, repair and inventory of equipment or property.	Facilities	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3200	Space Planning	Records related to planning and design of building offices and meeting spaces. Includes architectural drawings and designs, particularly for the building located at 505 City Parkway West.	Facilities	Duration of Building Ownership	Best Practice	Archive
ADM 3600	Video Surveillance / Monitoring	Recordings of routine video monitoring designed to record regular and ongoing operations such as building security systems. Excludes common areas such as the first floor lobby, as these areas are not under CalOptima Health purview.	Facilities	1 year with written consent from Legal Dept.	GOV 53160(a)	Delete
	Emergency Action and Fire Prevention Plans	Plans for evacuation of the facility in cases of emergency and other fire prevention plans. May include fire drill action plans, warden training and manual, and safety checklists.	Facilities	Rev	29 CFR 1910.38-.39; 8 CCR 3220	Shred/Delete
	Fire Extinguisher Records	Records related to the annual inspection and maintenance of fire extinguishers.	Facilities	Last entry + 2	29 CFR 1910.157 (e)(3); 8 CCR 6151(e)(3); GOV	Shred/Delete
	Fire Orders	Orders issued by the Fire Marshal to correct compliance with the fire code.	Facilities	CL + 2	SOS C-32; GOV 26202	Shred/Delete
	Fire Orders - PACE	Orders issued by the Fire Marshal to correct compliance with the fire code.	Facilities	Until Regulatory audit, + 2	GOV 26202; Gov. Contracts	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	First Aid Records	Records documenting one-time first aid treatment and subsequent observation of minor illnesses and injuries sustained onsite. Related to treatment provided by a non-physician and maintained separately from the employee medical records.	Facilities	CY + 5	29 CFR 1910.1020(d)(1)(i)(B)	Shred/Delete
	Hazardous Exposure	Records related to employee exposure to toxic substances or harmful physical agents.	Facilities	T + 30	29 CFR 1910.1020(d)(1)(ii); 8 CCR	Shred/Delete
	Hazardous Waste Records	Records related to the management of hazardous or medical waste. Includes registration, reporting, training and tracking documentation.	Facilities	CY + 3	22 CCR 66262.40; HSC 117945(a)(2); HSC 117938(b)(3); HSC	Shred/Delete
	Incident / Accident Report	Records related to the reporting and documentation of employee related incidents or accidents.	Facilities	CY + 5	29 CFR 1904.33; 8 CCR 14300.33	Shred/Delete
LEG 0400	Threat or Emergency Matters	Records related to receipt and response to threatening or emergency situations. May include correspondence, restraining orders or similar documentation.	Facilities / Legal Affairs	CL + 2	Best Practice; Legal recommendation	Shred/Delete
	Material Safety Data Sheets	MSDS (SDS) safety data sheets issued by manufacturers.	Facilities / PACE	T + 30	29 CFR 1910.1020(d)(1)(ii)(B)	Shred/Delete
ADM 0300	Bids - not accepted	Records of bid packets received where a contract is not awarded. May include the proposal, request for quotation (RFQ), Request for Proposal (RFP) or Request for Information (RFI). Includes all information provided by the applicant.	Finance	CL + 4	CCP 337; BPC 17208; GOV 26202	Shred/Delete
ADM 0700	Contracts and Agreements	The binding agreement to provide or receive goods or services. May include the original contract or agreement, all change orders, Business Associate Agreement (BAA), bidding exception forms, purchase orders, and any amendments. May also include the bid packets received in response to a request for proposal or other advertisement.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 1400	Insurance, Liability - Claims	Records related to denial or payment of claims made against liability insurance policies.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2); SOS C-24, 29 CFR 1904.33; CCP 337.15; 8 CCR 15400.2; 8	Shred/Delete
ADM 1700	Lease Agreements	Records related to rental agreements, capital leases, operations lease/purchase agreements or any other similar agreement and the amendments thereto.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Licenses - Property	Records related to property licenses such as our office buildings and PACE location.	Finance	P	Historical Value	Archive
ADM 1800	Licenses - Capital	Records related to capital expenditure licenses including those related to software or other information technology systems.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Assets - Property	Records related to the purchase or sale of capital assets such as real estate, including analysis and recommendations from CalOptima Health brokers, or buildings/construction. May include development rights.	Finance	P	42 CFR 422.504 (d)(1)(i)-(d)(2); CCP 337.15; Best Practice	Archive
	Budget - Approved	Official budget of the organization as submitted to and approved by the Board of Directors. May also be part of the packet and minutes of the Finance and Audit Committee and subject to their respective retention periods.	Finance	P	Historical Value; Best Practice	Archive
	Coding Analysis	Records documenting medical chart coding analysis including notation of questions or discrepancies that may lead to a denial of claims.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Provider Incentive	Records related to pay-for-value programs and other quality related incentives.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 1500	Insurance, Liability - Policies and	Documented agreement stating the obligations and responsibilities of each party.	Finance	P	Best Practice; SOS C-24	Archive
	Accounting Records	Records related to or involved in the preparation of financial statements or records relevant to audits and financial reviews. May include, when not related to tax, canceled checks, reconciled bank statements, cash flow statements, transaction summaries, journals, invoices, and vouchers.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Base Data	Records related to Medi-Cal rate development such as reported encounter data, cost and utilization data.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Budget - Supporting information	Records supporting budgetary expenses. May include approved budget, expense reports.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Capitation	Health network payment reconciliation and financial reports.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Financial Statements	Final audited financial statements maintained to demonstrate the ability to bear the risk of potential financial losses or to show services performed or determinations of amounts payable.	Finance	P	42 CFR 422.504 (d)(2)(iii); 42 CFR 438.3(h); Best Practice; Historical Value	Archive
	Health Network Solvency	Records related to the review of health network financial reports and regulatory filings to gauge their ability to pay claims.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Ledgers	Ledgers demonstrating the recordkeeping system of the organization's financial data with debit and credit account records validated by a trial balance. The general ledger shows a record for each financial transaction that takes place. Includes the general ledger and trial balances.	Finance	P	Best Practice	Archive
	Ledgers - supporting documentation	Records supporting the general revenue and expense accounting (financial transactions) for the organization.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Medical Loss Ratio (MLR) Reports - CalOptima Health	Reports generally representing a percentage of revenue used for patient care rather than for items such as administrative expenses or profit.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Medical Loss Ratio (MLR) Reports - Health Networks	Reports generally representing a percentage of revenue used for patient care rather than for items such as administrative expenses or profit.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Payroll	Records documenting salary as well as benefits, taxes and other withholdings of employees.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Tax Records	Records related to payment of taxes. May include tax returns (premiums, sales tax, Managed Care Organization tax, Foundation 990), and canceled checks demonstrating payment.	Finance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2); 18 CCR 19141.6 (h)(5)(i) (1)(A); 42 CFR 422.504 (d)(2)(iii); 42	Shred/Delete
	Encounters	Data submitted by our contracted health networks in support of services rendered to members. Submissions are based on the 837 5010 or XML formats, i.e., "universe files" for Audit & Oversight	Finance / Audit & Oversight	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Assets - Non-Property	Records related to the funding, purchase, acquisition and disposal of a non-property asset.	Finance / Information Technology Services / Facilities	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Constituent Case Work	Records related to addressing and processing member concerns initiated by elected officials or their staff.	Government Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Legislative Advocacy and Engagement	Records related to the tracking, monitoring, and possible advocacy of legislation that affects the mission of CalOptima Health. Includes community engagement, correspondence and rationale.	Government Affairs	CL + 2	GOV 26202; Best Practice for historical, trends, and benchmarking purposes	Shred/Delete
	Regulatory Advocacy and Engagement	Records related to the tracking, monitoring, and possible advocacy of regulations that affects the mission of CalOptima Health. Includes community engagement, correspondence and rationale.	Government Affairs	CL but no more than 2 years	GOV 26202; Best Practice for historical, trends, and benchmarking purposes	Shred/Delete
	Grievances and Appeals	Records related to member or provider grievances and any appeals to decisions rendered. Includes initial complaint, correspondence including the reason for the appeal or grievance, and resolution. Also includes supporting documentation for decisions made.	Grievance and Appeals Resolution Services / PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2000	Organizational Charts	Records of the organizational structure at any period of time.	Human Resources	P	Historical Value	Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Application and Selection Records - not hired	Records related to the application and selection process of persons not hired. May include application, interview notes, test results, background check and drug screening results, etc. (Records related to the individual hired become part of the personnel file.)	Human Resources	CL + 2	29 CFR 1627.3(b)(1)(i); 29 CFR 1602.31; 29 CFR 1602.30; GOV 12946; 2 CCR 11013; SOS C-21	Shred/Delete
	Benefits - Claims	Records documenting employee claims to benefits including the type of claim and benefit and / or payment received.	Human Resources	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Benefits - Leave ~~file~~	Records related to the benefits afforded each employee as part of a leave of absence. May include Family Medical Leave (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), benefits elections, beneficiary designations and eligibility determinations.	Human Resources	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Benefits - Plans	Records documenting employee benefits plans including but not limited to health, dental, disability, education, life, vision, dependent care, employee assistance, COBRA, Social Security and SSI records. Includes plan descriptions and terms with contribution methods and formulas.	Human Resources	P	29 USC 1027; 29 USC 1059; 29 CFR 1627.3; SOS C-20	Archive
	Employment Eligibility Verification (I-9 Form)	Employees' completed Employment Eligibility Verification form (I-9).	Human Resources	Employment start date + 3 years or T + 1 year, whichever is later	8 CFR 274a.2(b)(2)(i)(A)	Shred/Delete
	Employee Handbook	Record of the policies, practices and benefits for CalOptima Health employees.	Human Resources	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Equal Employment Opportunity (EEO)	Records related to compliance with the Equal Employment Opportunity Commission. May include survey responses, supplemental applications or other documents required to generate EEO reports.	Human Resources	CY + 3	29 CFR 1602.30	Shred/Delete
	Information / Media - Human Resources	Records related to communications from Human Resources to the workforce regarding benefits, open enrollment, training availability, and legal / statutory updates such as changes to leave requirements.	Human Resources	CY + 4	GOV 12960; Best Practice	Shred/Delete
	Job Descriptions	Records related to the creation, revision and finalization of job descriptions.	Human Resources	REV + 2	GOV 26202; Best Practice	Shred/Delete
	Medical Records - Employees	Records related to employee medical history, which is kept separate from the personnel file. May include pre-employment or subsequent drug screening results, and work related injury documentation.	Human Resources	T + 5	8 CCR 10102, 14300.33(a)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Pension / Retirement	Records related to eligibility and enrollment in retirement programs and information related to the associated benefits. Includes beneficiary forms.	Human Resources	T + 6	Best Practice for potential CalPERS audit of compensation	Shred/Delete
	Personnel Files - Human Resources	Records related to an employee's or resident's recruitment and retention. May include application/resume, background check results, conflict of interest (Form 700) (pre-online submittal process) pre-employment test results, training, acknowledgement forms, W-2, W-4, Direct Deposit information, job actions, performance evaluations including PIPs, and temporary / regular telework documentation.	Human Resources	T + 4	GOV 12946; 29 CFR 516.5; 42 USC 20000e-5(e)(3)	Shred/Delete
	Recruitment	Records related to the personnel recruitment process. May include the Request to Fill and internal correspondence.	Human Resources	CL + 3	29 CFR 1627.3(b)(1)(i); 29 CFR 1602.31; 29 CFR 1602.30; GOV 12946; 2	Shred/Delete
	Wage Rate Tables	Record of the amount of base wage paid to employees per unit of time. Data is retained to support calculated basis for retirement.	Human Resources	CY + 6 or P if attached to an approved implementing policy	29 CFR 516.6(a) (2); 2 CCR 570.5(a)(7); SOS C-19; Best Practice for potential CalPERS audit of compensation	Shred/Delete
ADM 1600	Insurance - Unemployment	Records documenting unemployment compensation claims as well as insurance premiums paid. May include employee status, claim details, pertinent correspondence, and materials related to unemployment compensation and insurance claims.	Human Resources	CL + 4	26 USC 3301-311; 26 CFR 31.6001-1(e)(2); 22 CCR 1085-2(c)	Shred/Delete
	Workers' Compensation	Records related to employee workers' compensation. Retention is based on the end of year in which the injury occurred or the last payment was made, whichever is later.	Human Resources	T + 4	GOV 12946; 29 CFR 516.5; 42 USC 20000e-5(e)(3)	Shred/Delete
	Workers' Compensation - Hazardous Exposure	Records related to employee workers' compensation for exposure to toxic substances or other harmful physical agents. Retention is based on the end of year in which the injury occurred.	Human Resources	T + 30	29 CFR 1910.1020(d)(ii) 8 CCR 3204(d) (1)(B)	Shred/Delete
	Work Schedules and Compensation	Records related to employees scheduled work days and hours and compensation received (salary and benefits). May include time cards and payroll documentation.	Human Resources / Finance	FY + 4	29 CFR 516.2; 29 CFR 1627.3; CCP 338(d)	Shred/Delete
ADM 1100	Disaster Recovery Plan	Records related to the creation, testing and, if needed, implementation of the disaster recovery plan, which is designed to ensure the organization can return to full functionality after a disaster occurs.	Information Technology Services	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
ADM 1300	Information Systems	Records related to the ownership and operation of financial, medical and other record keeping systems. May include documentation of system changes such as upgrades, coding, architecture, configurations, and outage / break-fix source and resolution information for significant system failures.	Information Technology Services	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2700	Records Disposition Certificates / Log	Records documenting the eligible records destroyed and the authorization to do so.	Information Technology Services	P	SOS C-23	Archive
ADM 2800	Records Retention Schedule	The approved records retention schedule that provides legal authority for the disposition of agency records.	Information Technology Services	P	CCP 343; Best Practice to support disposition	Archive
ADM 2900	Records Transfer List	The list of records transferred to an offsite location / vendor. Includes the container barcode numbers	Information Technology Services	Until destruction of all listed containers	Best Practice to support disposition	Shred/Delete
	Telephone Recordings	Routine and regular recording of telephone communications to and from the organization.	Information Technology Services	100 days with written consent from legal department	GOV 53160; GOV 26202.6; Best Practice	Delete
	Resource Guides and Program Manuals	Resources issued to assist providers with understanding the administrative processes related to providing health care services to members.	Issuing Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
LEG 0100	Legal Files	Records related to requests and responses to legal questions or concerns. May include Request for Legal Services (RLS) or other issued opinions.	Legal Affairs	CL + 1	Best Practice	Shred/Delete
LEG 0200	Litigation / Government Claims	Records related to litigation or claims by or against CalOptima Health. May include government claims, pleadings, transcripts, notices, or depositions.	Legal Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
LEG 0300	Subpoenas	Records related to the receipt and fulfillment of subpoenas (requests for records by an authorized third party). Includes original request, Authorization for Release of Protected Health Information (PHI), responsive documents, calculated fees, etc.	Legal Affairs / Information Services	CL + 2	GOV 26202; Best Practice	Shred/Delete
	Multipurpose Senior Services Program (MSSP)	Records related to the implementation of the MSSP including participant enrollment and care management information.	Long Term Services Support	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	MSSP Contract with California Department of Aging; Government Contracts; 42 CFR 438.3(h), (u); 42 CFR	Shred/Delete
	Social Media	Posts and stories created for CalOptima Health social media such as the official website, Instagram, Facebook, X, LinkedIn, or YouTube. Each platform retains content indefinitely.	Marketing & Communications	P	Best Practice	Archive

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Care Management	Records related to member care management. May include health risk assessments (HRAs) or other assessment tool, clinical screenings, care plans including discharge planning, PHI disclosure forms, progress notes, referrals, clinical or medical reviews, etc. Typically organized or retrieved by member.	Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Interdisciplinary Care Team Review	Records related to the interdisciplinary review of member health information to improve services and benefits. Includes medication review, provider statements and other related materials.	Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Medical Records	A written account of a member's examination and treatment that includes medical history and complaints, provider's findings, results of diagnostic tests and procedures, medications and therapeutic procedures, referrals, and discharge planning.	Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Quality of Care	Records related to the quality, appropriateness and timeliness of services performed as well as facilities utilized.	Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Provider Coordination	Records related to the internal coordination of provider services. May include distributed material review and approval, template maintenance, audit facilitation, etc., and related data.	Network Management	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 2100	Policies and Procedures	Records of the policies and procedures approved and implemented by the organization. Includes rationale for significant revisions.	Office of Compliance	P	Historical Value	Archive
	Audit Reports - Regulatory Agencies	Records related to audits of CalOptima Health conducted by regulatory agencies. May include audit report, Corrective Action Plans (CAPs) and correspondence.	Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Contracts and Agreements - government oversight	Contracts with and related correspondence to / from our government oversight bodies including CMS, DHCS, MSSP and PACE.	Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Fraud Referral Cases	Records related to the investigation of suspected fraud.	Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Investigations - HIPAA	Records related to investigations into suspected HIPAA violations. May include request from member or other to investigate, regulator reports and breach files.	Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Investigations - Non-Compliance (NCI)	Records related to investigations into suspected non-compliance. May include request to investigate and findings.	Office of Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Licenses - Operational	Records related to operational licenses or certificates such as Knox-Keene, Clinical Laboratory Improvement Amendment (CLIA), or other official State or Federal distinctions.	Office of Compliance	P	Best Practice; Historical Value	Archive
	Auditing/Monitoring Reports - Health Networks, FDRs, Pharmacies	Records related to audits performed by CalOptima Health of the organization's external health networks and First Tier, Downstream, and Related Entities (FDRs). May include audit notes and forms, Corrective Action Plans (CAPs) and correspondence.	Office of Compliance / Originating Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Auditing/Monitoring reports - Internal	Records related to audits performed by Office of Compliance on internal departments in order to gauge compliance with laws, regulations and internal policies. Includes large audits and smaller, more frequent monitoring. Includes correspondence, submitted documentation, findings, and any corrective actions.	Office of Compliance / Originating Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Protected Health Information Requests	Records documenting a member's request for access to or a copy of their designated record set. Includes the request and response.	Office of Compliance / PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Reporting - regulatory	Periodic and ad hoc reports of, for example, member and program utilization statistics often for program evaluation by state or federal agencies.	Office of Compliance / Reporting Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Emergency Action and Fire Prevention Plans - PACE	Plans for evacuation of the facility in cases of emergency and other fire prevention plans. May include fire drill action plans, warden training and manual, and safety checklists.	PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Fire Extinguisher Records - PACE	Records related to the annual inspection and maintenance of fire extinguishers.	PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	First Aid Records - PACE	Records documenting one-time first aid treatment and subsequent observation of minor illnesses and injuries sustained onsite. Related to treatment provided by a non-physician and maintained separately from the employee medical records.	PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Hazardous / Medical Waste Records - PACE	Records related to the management of hazardous or medical waste. Includes registration, reporting, training and tracking documentation.	PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Incident / Safety / Security Report - PACE	Records related to the reporting and documentation of employee related incidents or accidents.	PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Drug Formulary	Records related to the review and approval of member drug options. Includes rationale, drug codes, indications of which are covered or not.	Pharmacy	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Prescription Drug Denial / Appeal	Records related to the request for, denial of and, as applicable, appeal for prescription drugs.	Pharmacy / PACE	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Member Incentive Programs (MIP)	Records related to the creation and implementation of the various incentive / rewards programs. Includes eligibility, program materials, rewards distribution, and enrolled / denied member information.	Population Health	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Process Improvement - Workflows & Analysis	Records and resources related to process excellence initiatives including current and future state process flows, process playbooks, desktop procedures, implementation plans, key performance indicators, monitoring tools and data control plans.	Process Excellence / Program Implementation	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	In-Service	Records related to provider onboarding, orientation and annual training.	Provider Relations	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Provider Relations	Records related to establishing and maintaining a relationship with providers. Includes correspondence, add-change-term forms, meeting materials, newsletters, registration, provider directory validation, compliance and data accuracy attestations, change forms, training materials, etc.	Provider Relations / Provider Data Management Services	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Report to the Community (RTC)	The official report made to the community stating the agency's assets and liability and providing an overview of the agency's services and programs.	Public Affairs	P	Historical Value; Best Practice	Archive
	Financial Participation with External Entities	Records related to financial participation for external entities, such as charitable organizations, in furtherance of CalOptima Health's purpose pursuant to CalOptima Health Policy.	Public Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Quality Analytics	Records related to the analysis of current and historical data to predict trends, improve services and better manage resources in order to improve patient care.	Quality Analytics / Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Accreditation	Records related to the accreditation process and subsequent improvements for each reaccreditation effort. May include surveys results and responses.	Quality Improvement	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Credentialing	Records related to the credentialing and subsequent re-credentialing of physicians and providers. Includes applications, correspondence, supplemental information, exclusion screening results, Form 805 "Peer Review Report," etc.	Quality Improvement	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Facility Site Reviews	Records related to facility inspections and personnel interviews conducted on behalf of a regulatory body to determine if practices and systems on site meet survey criteria.	Quality Improvement	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Quality Improvement	Records related to the organization's continuous efforts to improve member services. Includes ad hoc reporting for purposes such as trend analysis, incident reports, PQIs (potential quality issue investigations), site reviews, and other oversight activities.	Quality Improvement / Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Delegation oversight	Records related to the review of delegated entities to ensure compliance with regulatory and contractual requirements as well as CalOptima Health policies and procedures.	Regulatory Affairs & Compliance	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Disenrollment Feedback Analysis	Records related to the review and analysis of member disenrollment feedback for the purpose of improving programs or outreach. Includes periodic data extractions, periodic and ad hoc summary reports, meeting minutes and the tracking of initiatives to evaluate improvements.	Sales & Marketing	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3300	Steering Groups	Records of the proceedings and minutes of decision and oversight groups regardless of their supporting or reporting role. Examples include Audit & Oversight, Compliance, Data and Information Governance, Pharmacy & Therapeutics, Quality Improvement, etc. Includes supporting elements of the agenda packet such as drug monographs or other decision making reference materials.	Sponsoring Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
	Education Programs	Records related to the acquisition, review and dissemination of education materials to members, providers and the public. Includes advertising/outreach, curricula, attendance rosters, handouts and other distributed materials or mailings.	Sponsoring Department	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete
ADM 3400	Strategic Plan	Records related to the creation and any significant revision to the organization's strategic plan.	Strategic Development	P	Historical Value	Archive
	Relationships and Initiatives	Records related to CalOptima Health's involvement in the community including attending meetings hosted by others, external collaborations, and participation in community initiatives. May include agendas, notes, action items, and minutes.	Strategic Development	Until Regulatory Audit, but not less than 2 years	GOV 26202	Shred/Delete
	Foundation	Records related to the CalOptima Health 501(c)3 foundation. Includes establishment and closure documentation and fund expenditures.	Strategic Development	P	Best Practice; Historical Value	Archive
	Grants	Records related to the application, award, implementation and conclusion of a grant. Includes records related to award and dispersal of grant funds. May include proposals, correspondence, financial or performance reports, etc.	Strategic Development / Department Receiving Funding	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Shred/Delete

Records Series	Area	Description	Responsible Department(s)	Retention	Citation / Rationale	Final Disposition
	Program Files	Records related to the creation, implementation and closure of public facing programs. Includes, as applicable, contracts, mission/vision statements, significant correspondence, receipt and distribution of funds, etc.	Strategic Development / Medical Affairs	10 years from the final date of the Government Contract period or from the date of completion of any audit, whichever is later	Government Contracts; 42 CFR 438.3(h), (u); 42 CFR 438.230(c); 42 CFR 422.504 (d)(2)	Archive

Code

Administration (ADM)
Community (COM)
Financial (FIN)
Health and Safety (HAS)
Legal (LEG)
Members (MEM)
Operations (OPR)
Personnel (PER)
Providers (PRO)
Regulatory / Compliance (REG)

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

12. Adopt Resolution No. 24-0801-01 Approving and Adopting Amended CalOptima Health Human Resources Policies

Contact

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

Recommended Actions

1. Adopt Resolution No. 24-0801-01 approving amended CalOptima Health policies:
   a. GA.8058: Salary Schedule and Attachment A approved May 2, 2024
   b. GA.8058: Salary Schedule and Attachment A approved May 4, 2023
   c. GA.8058: Salary Schedule and Attachment A approved December 1, 2022
   d. GA.8058: Salary Schedule and Attachment A approved June 2, 2022
   e. GA.8058: Salary Schedule and Attachment A approved March 3, 2022
   f. GA.8058: Salary Schedule and Attachment A approved September 2, 2021
   g. GA.8058: Salary Schedule and Attachment A approved August 5, 2021
   h. GA.8058: Salary Schedule and Attachment A approved March 4, 2021

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution and from time to time amend procedures, practices, and policies for, among other things, hiring employees and managing personnel. Additionally, pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima Health is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

In compliance with CalPERS requirements pertaining to the amount of compensation earnable pursuant to Government Code Sections 20630, 20636, and 20636.1, the payrate is limited to the amount listed on the CalOptima Health pay schedule. In addition, CalPERS requires that the pay schedule be duly approved and adopted by the CalOptima Health Board of Governors and the pay schedule indicate an effective date and date of any revisions. Historically, GA.8058 Salary Schedule Attachment A has used a "to be implemented" date to meet this the effective date requirement. CalPERS advised, and staff recommends, that "effective date" and "Approved by CalOptima Health Board of Directors" be added to current and three years of historical Salary Schedules for clarity and alignment with CalPERS pay schedule requirements.

Discussion

A list of policies and a summary of changes for the updated policies is included below.

GA.8058: Salary Schedule and Attachment A: This policy presents the CalOptima Health Salary Schedule. Staff proposes amending the naming convention used in the title of the current policy's Attachment A, CalOptima Health – Annual Base Salary Schedule, to include "effective date" and the same for three years of historical Salary Schedules.

Policy Section	Proposed Change	Rationale	Impact
Attachment A	Amend current and historical GA.8058 Salary Schedule Attachment A document header to include "Schedule Effective Date".	Compliance with CCR Section 570.5.	Provides clarity and alignment between the Salary Schedule and CalPERS compensation requirements.
GA.8058 IV. Attachments	Amend title of Attachment A.	To align title of Attachment A to its document header and include amendment date.	Provides clarity and document amendment date.

Fiscal Impact

The recommended action to revise the naming convention for current and previous versions of Attachment A to Policy GA.8058 has no fiscal impact.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 24-0801-01, Approve Amended Human Resources Policies
2. GA.8058: Salary Schedule and Attachment A approved May 2, 2024
3. GA.8058: Salary Schedule and Attachment A approved May 4, 2023
4. GA.8058: Salary Schedule and Attachment A approved December 1, 2022
5. GA.8058: Salary Schedule and Attachment A approved June 2, 2022
6. GA.8058: Salary Schedule and Attachment A approved March 3, 2022
7. GA.8058: Salary Schedule and Attachment A approved September 2, 2021
8. GA.8058: Salary Schedule and Attachment A approved August 5, 2021
9. GA.8058: Salary Schedule and Attachment A approved March 4, 2021

/s/ Michael Hunn   *07/25/2024*
Authorized Signature   **Date**

RESOLUTION NO. 24-0801-01

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

APPROVE AMENDED CALOPTIMA HEALTH POLICY

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose;

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima Health to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima Health regularly reviews CalOptima Health's salary schedule accordingly; and

WHEREAS, staff recommend that the existing salary schedule, and historical schedules for the previous three years, be updated to reflect an effective date as recommended by the California Public Employees' Retirement System.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following amended CalOptima Health policies:

a. GA.8058: Salary Schedule and Attachment A approved May 2, 2024;
b. GA.8058: Salary Schedule and Attachment A approved May 4, 2023;
c. GA.8058: Salary Schedule and Attachment A approved December 1, 2022;
d. GA.8058: Salary Schedule and Attachment A approved June 2, 2022;
e. GA.8058: Salary Schedule and Attachment A approved March 3, 2022;
f. GA.8058: Salary Schedule and Attachment A approved September 2, 2021;
g. GA.8058: Salary Schedule and Attachment A approved August 5, 2021; and
h. GA.8058: Salary Schedule and Attachment A approved March 4, 2021.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 1st day of August 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/__________________________________
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

Policy: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: */s/*

Effective Date: 05/01/2014
Revised Date: 05/02/2024

Applicable to:
☐ Medi-Cal
☐ OneCare
☐ PACE
☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima Health has established the attached salary schedule for each CalOptima Health job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Chief Human Resources Officer (CHRO) to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health - Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 05/02/2024; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
09/21/2015	Special Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	12/01/2022	GA.8058	Salary Schedule	Administrative
Revised	05/04/2023	GA.8058	Salary Schedule	Administrative
Revised	05/02/2024	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
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3 Not Applicable
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For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	05/02/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima Health has established the attached salary schedule for each CalOptima Health job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

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IV. ATTACHMENT(S)

A. CalOptima Health - Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 05/02/2024; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
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12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
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03/02/2017	Regular Meeting of the CalOptima Board of Directors
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11/02/2017	Regular Meeting of the CalOptima Board of Directors
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10/04/2018	Regular Meeting of the CalOptima Board of Directors
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08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY
3

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	12/01/2022	GA.8058	Salary Schedule	Administrative
Revised	05/04/2023	GA.8058	Salary Schedule	Administrative
Revised	05/02/2024	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
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3 Not Applicable
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For 20240801 BOD Review Only

Annual Base Salary Schedule~~-~~

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: May 5, 2024

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	307	39	$60,533	$77,179	$93,826
	Accountant II	310	634	$72,096	$93,724	$115,353
	Accountant III	311	68	$77,863	$101,222	$124,581
	Accountant IV	313	908	$90,820	$118,066	$145,312
	Accounting Clerk	302	334	$49,754	$59,704	$69,655
	Accounting Clerk Sr	304	680	$53,813	$67,267	$80,720
	Activity Coordinator (PACE)	305	681	$55,966	$69,958	$83,949
	Actuarial Analyst	310	558	$72,096	$93,724	$115,353
	Actuarial Analyst Sr	312	559	$84,092	$109,320	$134,548
	Actuary	315	357	$109,892	$142,859	$175,827
	Actuary Principal	317	882	$132,969	$172,860	$212,751
	Actuary Sr	316	883	$120,881	$157,145	$193,410
	Administrative Assistant	302	19	$49,754	$59,704	$69,655
	Administrative Fellow	309	902	$68,015	$88,419	$108,824
	Analyst	306	562	$58,205	$74,211	$90,217
	Analyst Int	308	563	$64,165	$83,414	$102,664
	Analyst Sr	310	564	$72,096	$93,724	$115,353
	Applications Analyst	308	232	$64,165	$83,414	$102,664
	Applications Analyst Int	309	233	$68,015	$88,419	$108,824
	Applications Analyst Sr	311	298	$77,863	$101,222	$124,581
	Associate Director I	318	884	$146,266	$190,146	$234,026
	Associate Director II	319	885	$160,893	$209,160	$257,428
	Auditor	309	565	$68,015	$88,419	$108,824
	Auditor Sr	310	566	$72,096	$93,724	$115,353
	Batch Automation Analyst	309	909	$68,015	$88,419	$108,824
	Batch Automation Analyst Sr	310	910	$72,096	$93,724	$115,353
	Biostatistics Manager	312	418	$84,092	$109,320	$134,548
	Business Analyst	310	40	$72,096	$93,724	$115,353
	Business Analyst Sr	311	611	$77,863	$101,222	$124,581
	Business Systems Analyst Sr	310	69	$72,096	$93,724	$115,353
	Buyer	306	29	$58,205	$74,211	$90,217
	Buyer Int	308	49	$64,165	$83,414	$102,664
	Buyer Sr	311	67	$77,863	$101,222	$124,581
	Care Manager	310	657	$72,096	$93,724	$115,353
	Care Transition Intervention Coach (RN)	313	417	$90,820	$118,066	$145,312
	Certified Coder	306	399	$58,205	$74,211	$90,217
	Certified Coding Specialist	306	639	$58,205	$74,211	$90,217
	Certified Coding Specialist Sr	309	640	$68,015	$88,419	$108,824
	Change Control Administrator	307	499	$60,533	$77,179	$93,826
	Change Control Administrator Int	309	500	$68,015	$88,419	$108,824
**	Chief Administrative Officer	327	TBD	$313,000	$414,450	$515,900
**	Chief Compliance Officer	327	888	$313,000	$414,450	$515,900

Annual Base Salary Schedule ~~–~~

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: May 5, 2024

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Executive Officer	330	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	328	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	327	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	327	890	$313,000	$414,450	$515,900
**	Chief Information Officer	327	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	328	137	$368,000	$487,600	$607,200
**	Chief of Staff	325	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	329	136	$433,000	$573,450	$713,900
	Claims - Lead	305	574	$55,966	$69,958	$83,949
	Claims Examiner	301	9	$47,840	$56,212	$64,584
	Claims Examiner - Lead	305	236	$55,966	$69,958	$83,949
	Claims Examiner Sr	303	20	$51,744	$62,092	$72,441
	Claims QA Analyst	304	28	$53,813	$67,267	$80,720
	Claims QA Analyst Sr	306	540	$58,205	$74,211	$90,217
	Claims Recovery Specialist	304	283	$53,813	$67,267	$80,720
	Claims Resolution Specialist	304	262	$53,813	$67,267	$80,720
	Clerk of the Board	315	59	$109,892	$142,859	$175,827
	Clinical Auditor	312	567	$84,092	$109,320	$134,548
	Clinical Auditor Sr	313	568	$90,820	$118,066	$145,312
	Clinical Documentation Specialist (RN)	313	641	$90,820	$118,066	$145,312
	Clinical Pharmacist	316	297	$120,881	$157,145	$193,410
	Clinical Systems Administrator	310	607	$72,096	$93,724	$115,353
	Clinical Trainer	313	903	$90,820	$118,066	$145,312
	Clinical Trainer (LVN)	312	904	$84,092	$109,320	$134,548
	Clinician (Behavioral Health)	310	513	$72,096	$93,724	$115,353
	Clinician Sr (Behavioral Health)	312	978	$84,092	$109,320	$134,548
	Cloud Engineer	315	912	$109,892	$142,859	$175,827
	Cloud Engineer Sr	316	913	$120,881	$157,145	$193,410
	Communications Specialist	306	188	$58,205	$74,211	$90,217
	Communications Specialist - Lead	309	707	$68,015	$88,419	$108,824
	Communications Specialist Sr	307	708	$60,533	$77,179	$93,826
	Community Partner	306	575	$58,205	$74,211	$90,217
	Community Partner Sr	308	612	$64,165	$83,414	$102,664
	Community Relations Specialist	306	288	$58,205	$74,211	$90,217
	Community Relations Specialist Sr	308	646	$64,165	$83,414	$102,664
	Compliance Claims Auditor	306	222	$58,205	$74,211	$90,217
	Compliance Claims Auditor Sr	307	279	$60,533	$77,179	$93,826
	Contract Administrator	311	385	$77,863	$101,222	$124,581
	Contracts Manager	313	207	$90,820	$118,066	$145,312
	Contracts Manager Sr	314	683	$99,902	$129,872	$159,843
	Contracts Specialist	308	257	$64,165	$83,414	$102,664
	Contracts Specialist Int	309	469	$68,015	$88,419	$108,824

Annual Base Salary Schedule–

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

Schedule Effective Date/To bBe iImplemented: May 5, 2024

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Contracts Specialist Sr	310	331	$72,096	$93,724	$115,353
*	Controller	323	464	$204,199	$265,458	$326,717
	Credentialing Coordinator	304	41	$53,813	$67,267	$80,720
	Credentialing Coordinator - Lead	306	510	$58,205	$74,211	$90,217
	Customer Service Coordinator	303	182	$51,744	$62,092	$72,441
	Customer Service Rep	301	5	$47,840	$56,212	$64,584
	Customer Service Rep - Lead	305	482	$55,966	$69,958	$83,949
	Customer Service Rep Sr	302	481	$49,754	$59,704	$69,655
	Cybersecurity Analyst	309	914	$68,015	$88,419	$108,824
	Cybersecurity Analyst Int	313	534	$90,820	$118,066	$145,312
	Cybersecurity Analyst Sr	314	474	$99,902	$129,872	$159,843
	Cybersecurity Engineer	316	915	$120,881	$157,145	$193,410
	Cybersecurity Engineer Sr	317	916	$132,969	$172,860	$212,751
	Cybersecurity Principal	319	917	$160,893	$209,160	$257,428
	Data Analyst	309	337	$68,015	$88,419	$108,824
	Data Analyst Int	310	341	$72,096	$93,724	$115,353
	Data Analyst Sr	312	342	$84,092	$109,320	$134,548
	Data and Reporting Analyst - Lead	314	654	$99,902	$129,872	$159,843
	Data Entry Tech	301	3	$47,840	$56,212	$64,584
	Data Warehouse Architect	315	363	$109,892	$142,859	$175,827
	Data Warehouse Programmer/Analyst	314	364	$99,902	$129,872	$159,843
	Data Warehouse Reporting Analyst	313	412	$90,820	$118,066	$145,312
	Data Warehouse Reporting Analyst Sr	314	522	$99,902	$129,872	$159,843
	Database Administrator	311	90	$77,863	$101,222	$124,581
	Database Administrator Sr	314	179	$99,902	$129,872	$159,843
**	Deputy Chief Medical Officer	327	561	$313,000	$414,450	$515,900
	Designer	310	387	$72,096	$93,724	$115,353
	Designer Sr	311	901	$77,863	$101,222	$124,581
*	Director I	320	891	$170,772	$222,003	$273,234
*	Director II	321	892	$181,257	$235,634	$290,011
*	Director III	322	893	$192,386	$250,102	$307,817
*	Director IV	323	894	$204,199	$265,458	$326,717
	Enrollment Coordinator (PACE)	304	441	$53,813	$67,267	$80,720
	Enterprise Analytics Manager	315	582	$109,892	$142,859	$175,827
	Executive Administrative Services Manager	311	661	$77,863	$101,222	$124,581
	Executive Assistant	307	339	$60,533	$77,179	$93,826
	Executive Assistant to CEO	309	261	$68,015	$88,419	$108,824
**	Executive Director	325	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	307	631	$60,533	$77,179	$93,826
	Facilities & Support Services Coordinator	304	10	$53,813	$67,267	$80,720
	Facilities & Support Services Coordinator Sr	305	511	$55,966	$69,958	$83,949
	Facilities Coordinator	304	438	$53,813	$67,267	$80,720

Annual Base Salary Schedule ~~–~~

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: May 5, 2024

Job Title	Pay Grade	Job Code	Min	Mid	Max
Financial Analyst I	309	51	$68,015	$88,419	$108,824
Financial Analyst II	312	84	$84,092	$109,320	$134,548
Financial Analyst III	313	905	$90,820	$118,066	$145,312
Financial Analyst IV	314	906	$99,902	$129,872	$159,843
Financial Reporting Analyst	308	475	$64,165	$83,414	$102,664
Grievance & Appeals Nurse Specialist	313	226	$90,820	$118,066	$145,312
Grievance Resolution Specialist	304	42	$53,813	$67,267	$80,720
Grievance Resolution Specialist - Lead	307	590	$60,533	$77,179	$93,826
Grievance Resolution Specialist Sr	306	589	$58,205	$74,211	$90,217
Health Coach	310	556	$72,096	$93,724	$115,353
Health Educator	307	47	$60,533	$77,179	$93,826
Health Educator Sr	308	355	$64,165	$83,414	$102,664
Health Network Liaison Specialist (RN)	313	524	$90,820	$118,066	$145,312
Health Network Oversight Specialist	310	323	$72,096	$93,724	$115,353
HEDIS Case Manager	313	443	$90,820	$118,066	$145,312
Human Resources Assistant	302	181	$49,754	$59,704	$69,655
Human Resources Business Partner	313	584	$90,820	$118,066	$145,312
Human Resources Coordinator	304	316	$53,813	$67,267	$80,720
Human Resources Representative	309	278	$68,015	$88,419	$108,824
Human Resources Representative Sr	312	350	$84,092	$109,320	$134,548
Human Resources Specialist	305	505	$55,966	$69,958	$83,949
Human Resources Specialist Sr	307	608	$60,533	$77,179	$93,826
Information Technology Services Coordinator	303	365	$51,744	$62,092	$72,441
Inpatient Quality Coding Auditor	308	642	$64,165	$83,414	$102,664
Intern	301	237	$47,840	$56,212	$64,584
Investigator	308	979	$64,165	$83,414	$102,664
Investigator Sr	310	553	$72,096	$93,724	$115,353
ITS Administrator	311	63	$77,863	$101,222	$124,581
ITS Administrator Sr	313	89	$90,820	$118,066	$145,312
ITS Analyst	308	918	$64,165	$83,414	$102,664
ITS Analyst Int	312	919	$84,092	$109,320	$134,548
ITS Analyst Sr	314	920	$99,902	$129,872	$159,843
ITS Architect II	315	921	$109,892	$142,859	$175,827
ITS Architect III	316	922	$120,881	$157,145	$193,410
ITS Architect IV	317	923	$132,969	$172,860	$212,751
ITS Developer Advisor	315	924	$109,892	$142,859	$175,827
ITS Product Manager	314	925	$99,902	$129,872	$159,843
ITS Product Manager Sr	315	926	$109,892	$142,859	$175,827
Kitchen Assistant	301	585	$47,840	$56,212	$64,584
Licensed Clinical Social Worker	311	598	$77,863	$101,222	$124,581
Litigation Support Specialist	310	588	$72,096	$93,724	$115,353
LVN (PACE)	311	533	$77,863	$101,222	$124,581

Annual Base Salary Schedule~~–~~

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

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Job Title	Pay Grade	Job Code	Min	Mid	Max
LVN Specialist	311	686	$77,863	$101,222	$124,581
Mailroom Clerk	301	1	$47,840	$56,212	$64,584
Manager Accounting	316	98	$120,881	$157,145	$193,410
Manager Actuary	318	453	$146,266	$190,146	$234,026
Manager Audit & Oversight	316	539	$120,881	$157,145	$193,410
Manager Behavioral Health	315	633	$109,892	$142,859	$175,827
Manager Business Integration	315	544	$109,892	$142,859	$175,827
Manager Case Management	316	270	$120,881	$157,145	$193,410
Manager Claims	315	92	$109,892	$142,859	$175,827
Manager Clinic Operations	316	551	$120,881	$157,145	$193,410
Manager Clinical Pharmacist	319	296	$160,893	$209,160	$257,428
Manager Coding Quality	314	382	$99,902	$129,872	$159,843
Manager Communications	314	398	$99,902	$129,872	$159,843
Manager Community Relations	314	384	$99,902	$129,872	$159,843
Manager Contracting	315	329	$109,892	$142,859	$175,827
Manager Cultural & Linguistic	313	349	$90,820	$118,066	$145,312
Manager Customer Service	313	94	$90,820	$118,066	$145,312
Manager Electronic Business	314	422	$99,902	$129,872	$159,843
Manager Encounters	314	516	$99,902	$129,872	$159,843
Manager Environmental Health & Safety	314	495	$99,902	$129,872	$159,843
Manager Finance	316	148	$120,881	$157,145	$193,410
Manager Financial Analysis	316	356	$120,881	$157,145	$193,410
Manager Government Affairs	314	437	$99,902	$129,872	$159,843
Manager Grievance & Appeals	315	426	$109,892	$142,859	$175,827
Manager Human Resources	315	526	$109,892	$142,859	$175,827
Manager Information Technology Services	316	560	$120,881	$157,145	$193,410
Manager Long Term Support Services	316	200	$120,881	$157,145	$193,410
Manager Marketing & Enrollment (PACE)	314	414	$99,902	$129,872	$159,843
Manager Member Liaison Program	313	354	$90,820	$118,066	$145,312
Manager Member Outreach & Education	313	616	$90,820	$118,066	$145,312
Manager MSSP	315	393	$109,892	$142,859	$175,827
Manager OneCare Clinical	316	359	$120,881	$157,145	$193,410
Manager OneCare Customer Service	313	429	$90,820	$118,066	$145,312
Manager Outreach & Enrollment	313	477	$90,820	$118,066	$145,312
Manager PACE Center	315	432	$109,892	$142,859	$175,827
Manager Population Health Management	314	674	$99,902	$129,872	$159,843
Manager Process Excellence	315	622	$109,892	$142,859	$175,827
Manager Program Implementation	314	488	$99,902	$129,872	$159,843
Manager Provider Data Management Services	313	653	$90,820	$118,066	$145,312
Manager Provider Network	315	191	$109,892	$142,859	$175,827
Manager Provider Relations	313	171	$90,820	$118,066	$145,312
Manager Purchasing	315	275	$109,892	$142,859	$175,827

Annual Base Salary Schedule~~–~~

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager QI Initiatives	313	433	$90,820	$118,066	$145,312
Manager Quality Analytics	314	617	$99,902	$129,872	$159,843
Manager Quality Improvement	314	104	$99,902	$129,872	$159,843
Manager Regulatory Affairs and Compliance	315	626	$109,892	$142,859	$175,827
Manager Reporting & Financial Compliance	315	572	$109,892	$142,859	$175,827
Manager Strategic Development	316	603	$120,881	$157,145	$193,410
Manager Utilization Management	316	250	$120,881	$157,145	$193,410
Marketing and Outreach Specialist	305	496	$55,966	$69,958	$83,949
Marketing and Outreach Specialist Sr	308	980	$64,165	$83,414	$102,664
Medical Assistant	302	535	$49,754	$59,704	$69,655
Medical Authorization Asst	302	11	$49,754	$59,704	$69,655
Medical Case Manager	313	72	$90,820	$118,066	$145,312
Medical Case Manager (LVN)	311	444	$77,863	$101,222	$124,581
* Medical Director	326	306	$266,000	$365,034	$464,068
Medical Records & Health Plan Assistant	301	548	$47,840	$56,212	$64,584
Medical Records Clerk	301	523	$47,840	$56,212	$64,584
Medical Services Case Manager	307	54	$60,533	$77,179	$93,826
Member Liaison Specialist	302	353	$49,754	$59,704	$69,655
Member Liaison Specialist Sr	303	981	$51,744	$62,092	$72,441
MMS Program Coordinator	306	360	$58,205	$74,211	$90,217
Network Engineer	315	927	$109,892	$142,859	$175,827
Network Engineer Principal	317	928	$132,969	$172,860	$212,751
Network Engineer Sr	316	929	$120,881	$157,145	$193,410
Nurse Practitioner (PACE)	316	635	$120,881	$157,145	$193,410
Occupational Therapist	312	531	$84,092	$109,320	$134,548
Occupational Therapist Assistant	308	623	$64,165	$83,414	$102,664
Office Clerk	301	335	$47,840	$56,212	$64,584
OneCare Operations Manager	315	461	$109,892	$142,859	$175,827
OneCare Partner - Sales	305	230	$55,966	$69,958	$83,949
OneCare Partner - Sales (Lead)	307	537	$60,533	$77,179	$93,826
OneCare Partner - Service	301	231	$47,840	$56,212	$64,584
OneCare Partner (Inside Sales)	303	371	$51,744	$62,092	$72,441
Outreach Specialist	301	218	$47,840	$56,212	$64,584
Paralegal/Legal Secretary	308	376	$64,165	$83,414	$102,664
Payroll Specialist	304	554	$53,813	$67,267	$80,720
Payroll Specialist Sr	306	688	$58,205	$74,211	$90,217
Performance Analyst	308	538	$64,165	$83,414	$102,664
Personal Care Attendant	301	485	$47,840	$56,212	$64,584
Personal Care Attendant - Lead	302	498	$49,754	$59,704	$69,655
Personal Care Coordinator	303	525	$51,744	$62,092	$72,441
Personal Care Coordinator Sr	304	689	$53,813	$67,267	$80,720
Pharmacy Resident	305	379	$55,966	$69,958	$83,949

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Pharmacy Services Specialist	301	23	$47,840	$56,212	$64,584
Pharmacy Services Specialist Int	302	35	$49,754	$59,704	$69,655
Pharmacy Services Specialist Sr	304	507	$53,813	$67,267	$80,720
Physical Therapist	312	530	$84,092	$109,320	$134,548
Physical Therapist Assistant	308	624	$64,165	$83,414	$102,664
Policy Advisor Sr	312	580	$84,092	$109,320	$134,548
Principal Financial Analyst	315	907	$109,892	$142,859	$175,827
Privacy Manager	315	536	$109,892	$142,859	$175,827
Privacy Officer	315	648	$109,892	$142,859	$175,827
Process Excellence Manager I	307	930	$60,533	$77,179	$93,826
Process Excellence Manager II	310	931	$72,096	$93,724	$115,353
Process Excellence Manager III	313	932	$90,820	$118,066	$145,312
Process Excellence Manager IV	315	933	$109,892	$142,859	$175,827
Program Assistant	302	24	$49,754	$59,704	$69,655
Program Coordinator	303	284	$51,744	$62,092	$72,441
Program Development Analyst Sr	311	492	$77,863	$101,222	$124,581
Program Manager	311	421	$77,863	$101,222	$124,581
Program Manager Sr	313	594	$90,820	$118,066	$145,312
Program Specialist	305	36	$55,966	$69,958	$83,949
Program Specialist Int	307	61	$60,533	$77,179	$93,826
Program Specialist Sr	309	508	$68,015	$88,419	$108,824
Program/Policy Analyst	309	56	$68,015	$88,419	$108,824
Program/Policy Analyst Sr	311	85	$77,863	$101,222	$124,581
Programmer	310	43	$72,096	$93,724	$115,353
Programmer Int	313	74	$90,820	$118,066	$145,312
Programmer Sr	314	80	$99,902	$129,872	$159,843
Project Manager I	308	934	$64,165	$83,414	$102,664
Project Manager II	312	935	$84,092	$109,320	$134,548
Project Manager III	315	936	$109,892	$142,859	$175,827
Project Manager IV	316	937	$120,881	$157,145	$193,410
Project Specialist	304	291	$53,813	$67,267	$80,720
Provider Data Management Services Coordinator	303	12	$51,744	$62,092	$72,441
Provider Data Management Services Coordinator Sr	305	586	$55,966	$69,958	$83,949
Provider Enrollment Manager	306	190	$58,205	$74,211	$90,217
Provider Network Rep Sr	308	391	$64,165	$83,414	$102,664
Provider Network Specialist	307	44	$60,533	$77,179	$93,826
Provider Network Specialist Sr	309	595	$68,015	$88,419	$108,824
Provider Office Education Manager	307	300	$60,533	$77,179	$93,826
Provider Relations Rep	306	205	$58,205	$74,211	$90,217
Provider Relations Rep Sr	308	285	$64,165	$83,414	$102,664
Publications Coordinator	306	293	$58,205	$74,211	$90,217
QA Analyst	309	486	$68,015	$88,419	$108,824

Annual Base Salary Schedule ~~–~~

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Job Title	Pay Grade	Job Code	Min	Mid	Max
QA Analyst Sr	312	380	$84,092	$109,320	$134,548
QA Test Automation Engineer	310	938	$72,096	$93,724	$115,353
QA Test Automation Engineer Advisor	315	939	$109,892	$142,859	$175,827
QA Test Automation Engineer Sr.	314	940	$99,902	$129,872	$159,843
QI Nurse Specialist	313	82	$90,820	$118,066	$145,312
QI Nurse Specialist (LVN)	312	445	$84,092	$109,320	$134,548
Quality Improvement Specialist	309	982	$68,015	$88,419	$108,824
Quality Improvement Specialist Sr	311	983	$77,863	$101,222	$124,581
Receptionist	301	140	$47,840	$56,212	$64,584
Records Manager	317	778	$132,969	$172,860	$212,751
Recreational Therapist	306	487	$58,205	$74,211	$90,217
Registered Dietitian	310	57	$72,096	$93,724	$115,353
Regulatory Affairs and Compliance - Lead	311	630	$77,863	$101,222	$124,581
Regulatory Affairs and Compliance Analyst	309	628	$68,015	$88,419	$108,824
Regulatory Affairs and Compliance Analyst Sr	310	629	$72,096	$93,724	$115,353
RN (PACE)	313	480	$90,820	$118,066	$145,312
Security Officer	301	311	$47,840	$56,212	$64,584
Service Desk Technician	304	571	$53,813	$67,267	$80,720
Service Desk Technician Sr	305	573	$55,966	$69,958	$83,949
SharePoint Developer/Administrator Sr	314	397	$99,902	$129,872	$159,843
Social Worker	309	463	$68,015	$88,419	$108,824
Social Worker Sr	310	690	$72,096	$93,724	$115,353
Speech Therapist	312	941	$84,092	$109,320	$134,548
* Sr Director	324	896	$216,737	$281,757	$346,778
Sr Manager I	316	897	$120,881	$157,145	$193,410
Sr Manager II	317	898	$132,969	$172,860	$212,751
Sr Manager III	318	899	$146,266	$190,146	$234,026
Sr Manager IV	319	900	$160,893	$209,160	$257,428
Supervisor Accounting	314	434	$99,902	$129,872	$159,843
Supervisor Audit and Oversight	313	618	$90,820	$118,066	$145,312
Supervisor Behavioral Health	313	659	$90,820	$118,066	$145,312
Supervisor Budgeting	314	466	$99,902	$129,872	$159,843
Supervisor Case Management	315	86	$109,892	$142,859	$175,827
Supervisor Claims	312	219	$84,092	$109,320	$134,548
Supervisor Coding Initiatives	313	502	$90,820	$118,066	$145,312
Supervisor Credentialing	308	671	$64,165	$83,414	$102,664
Supervisor Customer Service	308	34	$64,165	$83,414	$102,664
Supervisor Data Entry	306	192	$58,205	$74,211	$90,217
Supervisor Day Center (PACE)	306	619	$58,205	$74,211	$90,217
Supervisor Dietary Services (PACE)	312	643	$84,092	$109,320	$134,548
Supervisor Encounters	307	253	$60,533	$77,179	$93,826
Supervisor Facilities	310	162	$72,096	$93,724	$115,353

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Finance	314	419	$99,902	$129,872	$159,843
Supervisor Grievance and Appeals	312	620	$84,092	$109,320	$134,548
Supervisor Information Technology Services	314	457	$99,902	$129,872	$159,843
Supervisor Long Term Support Services	315	587	$109,892	$142,859	$175,827
Supervisor Medical Assistant	306	984	$58,205	$74,211	$90,217
Supervisor Member Outreach and Education	311	592	$77,863	$101,222	$124,581
Supervisor MSSP	314	348	$99,902	$129,872	$159,843
Supervisor Nursing Services (PACE)	315	662	$109,892	$142,859	$175,827
Supervisor OneCare Customer Service	308	408	$64,165	$83,414	$102,664
Supervisor Payroll	313	517	$90,820	$118,066	$145,312
Supervisor Pharmacist	317	610	$132,969	$172,860	$212,751
Supervisor Population Health Management	313	673	$90,820	$118,066	$145,312
Supervisor Provider Data Management Services	311	439	$77,863	$101,222	$124,581
Supervisor Provider Relations	312	652	$84,092	$109,320	$134,548
Supervisor Quality Analytics	313	609	$90,820	$118,066	$145,312
Supervisor Quality Improvement	313	600	$90,820	$118,066	$145,312
Supervisor Regulatory Affairs and Compliance	313	627	$90,820	$118,066	$145,312
Supervisor Social Work (PACE)	313	636	$90,820	$118,066	$145,312
Supervisor Therapy Services (PACE)	314	645	$99,902	$129,872	$159,843
Supervisor Utilization Management	315	637	$109,892	$142,859	$175,827
Systems Operations Analyst	304	32	$53,813	$67,267	$80,720
Systems Operations Analyst Int	307	45	$60,533	$77,179	$93,826
Technical Analyst Int	309	64	$68,015	$88,419	$108,824
Technical Analyst Sr	312	75	$84,092	$109,320	$134,548
Technical Support Specialist Sr	307	942	$60,533	$77,179	$93,826
Telephony Engineer	314	943	$99,902	$129,872	$159,843
Telephony Engineer Sr	316	944	$120,881	$157,145	$193,410
Therapy Aide	304	521	$53,813	$67,267	$80,720
Training Administrator	308	621	$64,165	$83,414	$102,664
Training Program Coordinator	306	471	$58,205	$74,211	$90,217
Translation Specialist	305	241	$55,966	$69,958	$83,949
Web Architect	314	366	$99,902	$129,872	$159,843

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	307	39	$60,533	$77,179	$93,826
	Accountant II	310	634	$72,096	$93,724	$115,353
	Accountant III	311	68	$77,863	$101,222	$124,581
	Accountant IV	313	908	$90,820	$118,066	$145,312
	Accounting Clerk	302	334	$49,754	$59,704	$69,655
	Accounting Clerk Sr	304	680	$53,813	$67,267	$80,720
	Activity Coordinator (PACE)	305	681	$55,966	$69,958	$83,949
	Actuarial Analyst	310	558	$72,096	$93,724	$115,353
	Actuarial Analyst Sr	312	559	$84,092	$109,320	$134,548
	Actuary	315	357	$109,892	$142,859	$175,827
	Actuary Principal	317	882	$132,969	$172,860	$212,751
	Actuary Sr	316	883	$120,881	$157,145	$193,410
	Administrative Assistant	302	19	$49,754	$59,704	$69,655
	Administrative Fellow	309	902	$68,015	$88,419	$108,824
	Analyst	306	562	$58,205	$74,211	$90,217
	Analyst Int	308	563	$64,165	$83,414	$102,664
	Analyst Sr	310	564	$72,096	$93,724	$115,353
	Applications Analyst	308	232	$64,165	$83,414	$102,664
	Applications Analyst Int	309	233	$68,015	$88,419	$108,824
	Applications Analyst Sr	311	298	$77,863	$101,222	$124,581
	Associate Director I	318	884	$146,266	$190,146	$234,026
	Associate Director II	319	885	$160,893	$209,160	$257,428
	Auditor	309	565	$68,015	$88,419	$108,824
	Auditor Sr	310	566	$72,096	$93,724	$115,353
	Batch Automation Analyst	309	909	$68,015	$88,419	$108,824
	Batch Automation Analyst Sr	310	910	$72,096	$93,724	$115,353
	Biostatistics Manager	312	418	$84,092	$109,320	$134,548
	Business Analyst	310	40	$72,096	$93,724	$115,353
	Business Analyst Sr	311	611	$77,863	$101,222	$124,581
	Business Systems Analyst Sr	310	69	$72,096	$93,724	$115,353
	Buyer	306	29	$58,205	$74,211	$90,217
	Buyer Int	308	49	$64,165	$83,414	$102,664
	Buyer Sr	311	67	$77,863	$101,222	$124,581
	Care Manager	310	657	$72,096	$93,724	$115,353
	Care Transition Intervention Coach (RN)	313	417	$90,820	$118,066	$145,312
	Certified Coder	306	399	$58,205	$74,211	$90,217
	Certified Coding Specialist	306	639	$58,205	$74,211	$90,217
	Certified Coding Specialist Sr	309	640	$68,015	$88,419	$108,824
	Change Control Administrator	307	499	$60,533	$77,179	$93,826
	Change Control Administrator Int	309	500	$68,015	$88,419	$108,824
**	Chief Administrative Officer	327	TBD	$313,000	$414,450	$515,900
**	Chief Compliance Officer	327	888	$313,000	$414,450	$515,900

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Job Title	Pay Grade	Job Code	Min	Mid	Max
** Chief Executive Officer	330	138	$560,000	$700,750	$841,500
** Chief Financial Officer	328	134	$368,000	$487,600	$607,200
** Chief Health Equity Officer	327	889	$313,000	$414,450	$515,900
** Chief Human Resources Officer	327	890	$313,000	$414,450	$515,900
** Chief Information Officer	327	131	$313,000	$414,450	$515,900
** Chief Medical Officer	328	137	$368,000	$487,600	$607,200
** Chief of Staff	325	692	$226,000	$298,900	$371,800
** Chief Operating Officer	329	136	$433,000	$573,450	$713,900
Claims - Lead	305	574	$55,966	$69,958	$83,949
Claims Examiner	301	9	$47,840	$56,212	$64,584
Claims Examiner - Lead	305	236	$55,966	$69,958	$83,949
Claims Examiner Sr	303	20	$51,744	$62,092	$72,441
Claims QA Analyst	304	28	$53,813	$67,267	$80,720
Claims QA Analyst Sr	306	540	$58,205	$74,211	$90,217
Claims Recovery Specialist	304	283	$53,813	$67,267	$80,720
Claims Resolution Specialist	304	262	$53,813	$67,267	$80,720
Clerk of the Board	315	59	$109,892	$142,859	$175,827
Clinical Auditor	312	567	$84,092	$109,320	$134,548
Clinical Auditor Sr	313	568	$90,820	$118,066	$145,312
Clinical Documentation Specialist (RN)	313	641	$90,820	$118,066	$145,312
Clinical Pharmacist	316	297	$120,881	$157,145	$193,410
Clinical Systems Administrator	310	607	$72,096	$93,724	$115,353
Clinical Trainer	313	903	$90,820	$118,066	$145,312
Clinical Trainer (LVN)	312	904	$84,092	$109,320	$134,548
Clinician (Behavioral Health)	310	513	$72,096	$93,724	$115,353
Clinician Sr (Behavioral Health)	312	978	$84,092	$109,320	$134,548
Cloud Engineer	315	912	$109,892	$142,859	$175,827
Cloud Engineer Sr	316	913	$120,881	$157,145	$193,410
Communications Specialist	306	188	$58,205	$74,211	$90,217
Communications Specialist - Lead	309	707	$68,015	$88,419	$108,824
Communications Specialist Sr	307	708	$60,533	$77,179	$93,826
Community Partner	306	575	$58,205	$74,211	$90,217
Community Partner Sr	308	612	$64,165	$83,414	$102,664
Community Relations Specialist	306	288	$58,205	$74,211	$90,217
Community Relations Specialist Sr	308	646	$64,165	$83,414	$102,664
Compliance Claims Auditor	306	222	$58,205	$74,211	$90,217
Compliance Claims Auditor Sr	307	279	$60,533	$77,179	$93,826
Contract Administrator	311	385	$77,863	$101,222	$124,581
Contracts Manager	313	207	$90,820	$118,066	$145,312
Contracts Manager Sr	314	683	$99,902	$129,872	$159,843
Contracts Specialist	308	257	$64,165	$83,414	$102,664
Contracts Specialist Int	309	469	$68,015	$88,419	$108,824

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Contracts Specialist Sr	310	331	$72,096	$93,724	$115,353
*	Controller	323	464	$204,199	$265,458	$326,717
	Credentialing Coordinator	304	41	$53,813	$67,267	$80,720
	Credentialing Coordinator - Lead	306	510	$58,205	$74,211	$90,217
	Customer Service Coordinator	303	182	$51,744	$62,092	$72,441
	Customer Service Rep	301	5	$47,840	$56,212	$64,584
	Customer Service Rep - Lead	305	482	$55,966	$69,958	$83,949
	Customer Service Rep Sr	302	481	$49,754	$59,704	$69,655
	Cybersecurity Analyst	309	914	$68,015	$88,419	$108,824
	Cybersecurity Analyst Int	313	534	$90,820	$118,066	$145,312
	Cybersecurity Analyst Sr	314	474	$99,902	$129,872	$159,843
	Cybersecurity Engineer	316	915	$120,881	$157,145	$193,410
	Cybersecurity Engineer Sr	317	916	$132,969	$172,860	$212,751
	Cybersecurity Principal	319	917	$160,893	$209,160	$257,428
	Data Analyst	309	337	$68,015	$88,419	$108,824
	Data Analyst Int	310	341	$72,096	$93,724	$115,353
	Data Analyst Sr	312	342	$84,092	$109,320	$134,548
	Data and Reporting Analyst - Lead	314	654	$99,902	$129,872	$159,843
	Data Entry Tech	301	3	$47,840	$56,212	$64,584
	Data Warehouse Architect	315	363	$109,892	$142,859	$175,827
	Data Warehouse Programmer/Analyst	314	364	$99,902	$129,872	$159,843
	Data Warehouse Reporting Analyst	313	412	$90,820	$118,066	$145,312
	Data Warehouse Reporting Analyst Sr	314	522	$99,902	$129,872	$159,843
	Database Administrator	311	90	$77,863	$101,222	$124,581
	Database Administrator Sr	314	179	$99,902	$129,872	$159,843
**	Deputy Chief Medical Officer	327	561	$313,000	$414,450	$515,900
	Designer	310	387	$72,096	$93,724	$115,353
	Designer Sr	311	901	$77,863	$101,222	$124,581
*	Director I	320	891	$170,772	$222,003	$273,234
*	Director II	321	892	$181,257	$235,634	$290,011
*	Director III	322	893	$192,386	$250,102	$307,817
*	Director IV	323	894	$204,199	$265,458	$326,717
	Enrollment Coordinator (PACE)	304	441	$53,813	$67,267	$80,720
	Enterprise Analytics Manager	315	582	$109,892	$142,859	$175,827
	Executive Administrative Services Manager	311	661	$77,863	$101,222	$124,581
	Executive Assistant	307	339	$60,533	$77,179	$93,826
	Executive Assistant to CEO	309	261	$68,015	$88,419	$108,824
**	Executive Director	325	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	307	631	$60,533	$77,179	$93,826
	Facilities & Support Services Coordinator	304	10	$53,813	$67,267	$80,720
	Facilities & Support Services Coordinator Sr	305	511	$55,966	$69,958	$83,949
	Facilities Coordinator	304	438	$53,813	$67,267	$80,720

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Financial Analyst I	309	51	$68,015	$88,419	$108,824
Financial Analyst II	312	84	$84,092	$109,320	$134,548
Financial Analyst III	313	905	$90,820	$118,066	$145,312
Financial Analyst IV	314	906	$99,902	$129,872	$159,843
Financial Reporting Analyst	308	475	$64,165	$83,414	$102,664
Grievance & Appeals Nurse Specialist	313	226	$90,820	$118,066	$145,312
Grievance Resolution Specialist	304	42	$53,813	$67,267	$80,720
Grievance Resolution Specialist - Lead	307	590	$60,533	$77,179	$93,826
Grievance Resolution Specialist Sr	306	589	$58,205	$74,211	$90,217
Health Coach	310	556	$72,096	$93,724	$115,353
Health Educator	307	47	$60,533	$77,179	$93,826
Health Educator Sr	308	355	$64,165	$83,414	$102,664
Health Network Liaison Specialist (RN)	313	524	$90,820	$118,066	$145,312
Health Network Oversight Specialist	310	323	$72,096	$93,724	$115,353
HEDIS Case Manager	313	443	$90,820	$118,066	$145,312
Human Resources Assistant	302	181	$49,754	$59,704	$69,655
Human Resources Business Partner	313	584	$90,820	$118,066	$145,312
Human Resources Coordinator	304	316	$53,813	$67,267	$80,720
Human Resources Representative	309	278	$68,015	$88,419	$108,824
Human Resources Representative Sr	312	350	$84,092	$109,320	$134,548
Human Resources Specialist	305	505	$55,966	$69,958	$83,949
Human Resources Specialist Sr	307	608	$60,533	$77,179	$93,826
Information Technology Services Coordinator	303	365	$51,744	$62,092	$72,441
Inpatient Quality Coding Auditor	308	642	$64,165	$83,414	$102,664
Intern	301	237	$47,840	$56,212	$64,584
Investigator	308	979	$64,165	$83,414	$102,664
Investigator Sr	310	553	$72,096	$93,724	$115,353
ITS Administrator	311	63	$77,863	$101,222	$124,581
ITS Administrator Sr	313	89	$90,820	$118,066	$145,312
ITS Analyst	308	918	$64,165	$83,414	$102,664
ITS Analyst Int	312	919	$84,092	$109,320	$134,548
ITS Analyst Sr	314	920	$99,902	$129,872	$159,843
ITS Architect II	315	921	$109,892	$142,859	$175,827
ITS Architect III	316	922	$120,881	$157,145	$193,410
ITS Architect IV	317	923	$132,969	$172,860	$212,751
ITS Developer Advisor	315	924	$109,892	$142,859	$175,827
ITS Product Manager	314	925	$99,902	$129,872	$159,843
ITS Product Manager Sr	315	926	$109,892	$142,859	$175,827
Kitchen Assistant	301	585	$47,840	$56,212	$64,584
Licensed Clinical Social Worker	311	598	$77,863	$101,222	$124,581
Litigation Support Specialist	310	588	$72,096	$93,724	$115,353
LVN (PACE)	311	533	$77,863	$101,222	$124,581

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Job Title	Pay Grade	Job Code	Min	Mid	Max
LVN Specialist	311	686	$77,863	$101,222	$124,581
Mailroom Clerk	301	1	$47,840	$56,212	$64,584
Manager Accounting	316	98	$120,881	$157,145	$193,410
Manager Actuary	318	453	$146,266	$190,146	$234,026
Manager Audit & Oversight	316	539	$120,881	$157,145	$193,410
Manager Behavioral Health	315	633	$109,892	$142,859	$175,827
Manager Business Integration	315	544	$109,892	$142,859	$175,827
Manager Case Management	316	270	$120,881	$157,145	$193,410
Manager Claims	315	92	$109,892	$142,859	$175,827
Manager Clinic Operations	316	551	$120,881	$157,145	$193,410
Manager Clinical Pharmacist	319	296	$160,893	$209,160	$257,428
Manager Coding Quality	314	382	$99,902	$129,872	$159,843
Manager Communications	314	398	$99,902	$129,872	$159,843
Manager Community Relations	314	384	$99,902	$129,872	$159,843
Manager Contracting	315	329	$109,892	$142,859	$175,827
Manager Cultural & Linguistic	313	349	$90,820	$118,066	$145,312
Manager Customer Service	313	94	$90,820	$118,066	$145,312
Manager Electronic Business	314	422	$99,902	$129,872	$159,843
Manager Encounters	314	516	$99,902	$129,872	$159,843
Manager Environmental Health & Safety	314	495	$99,902	$129,872	$159,843
Manager Finance	316	148	$120,881	$157,145	$193,410
Manager Financial Analysis	316	356	$120,881	$157,145	$193,410
Manager Government Affairs	314	437	$99,902	$129,872	$159,843
Manager Grievance & Appeals	315	426	$109,892	$142,859	$175,827
Manager Human Resources	315	526	$109,892	$142,859	$175,827
Manager Information Technology Services	316	560	$120,881	$157,145	$193,410
Manager Long Term Support Services	316	200	$120,881	$157,145	$193,410
Manager Marketing & Enrollment (PACE)	314	414	$99,902	$129,872	$159,843
Manager Member Liaison Program	313	354	$90,820	$118,066	$145,312
Manager Member Outreach & Education	313	616	$90,820	$118,066	$145,312
Manager MSSP	315	393	$109,892	$142,859	$175,827
Manager OneCare Clinical	316	359	$120,881	$157,145	$193,410
Manager OneCare Customer Service	313	429	$90,820	$118,066	$145,312
Manager Outreach & Enrollment	313	477	$90,820	$118,066	$145,312
Manager PACE Center	315	432	$109,892	$142,859	$175,827
Manager Population Health Management	314	674	$99,902	$129,872	$159,843
Manager Process Excellence	315	622	$109,892	$142,859	$175,827
Manager Program Implementation	314	488	$99,902	$129,872	$159,843
Manager Provider Data Management Services	313	653	$90,820	$118,066	$145,312
Manager Provider Network	315	191	$109,892	$142,859	$175,827
Manager Provider Relations	313	171	$90,820	$118,066	$145,312
Manager Purchasing	315	275	$109,892	$142,859	$175,827

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager QI Initiatives	313	433	$90,820	$118,066	$145,312
	Manager Quality Analytics	314	617	$99,902	$129,872	$159,843
	Manager Quality Improvement	314	104	$99,902	$129,872	$159,843
	Manager Regulatory Affairs and Compliance	315	626	$109,892	$142,859	$175,827
	Manager Reporting & Financial Compliance	315	572	$109,892	$142,859	$175,827
	Manager Strategic Development	316	603	$120,881	$157,145	$193,410
	Manager Utilization Management	316	250	$120,881	$157,145	$193,410
	Marketing and Outreach Specialist	305	496	$55,966	$69,958	$83,949
	Marketing and Outreach Specialist Sr	308	980	$64,165	$83,414	$102,664
	Medical Assistant	302	535	$49,754	$59,704	$69,655
	Medical Authorization Asst	302	11	$49,754	$59,704	$69,655
	Medical Case Manager	313	72	$90,820	$118,066	$145,312
	Medical Case Manager (LVN)	311	444	$77,863	$101,222	$124,581
*	Medical Director	326	306	$266,000	$365,034	$464,068
	Medical Records & Health Plan Assistant	301	548	$47,840	$56,212	$64,584
	Medical Records Clerk	301	523	$47,840	$56,212	$64,584
	Medical Services Case Manager	307	54	$60,533	$77,179	$93,826
	Member Liaison Specialist	302	353	$49,754	$59,704	$69,655
	Member Liaison Specialist Sr	303	981	$51,744	$62,092	$72,441
	MMS Program Coordinator	306	360	$58,205	$74,211	$90,217
	Network Engineer	315	927	$109,892	$142,859	$175,827
	Network Engineer Principal	317	928	$132,969	$172,860	$212,751
	Network Engineer Sr	316	929	$120,881	$157,145	$193,410
	Nurse Practitioner (PACE)	316	635	$120,881	$157,145	$193,410
	Occupational Therapist	312	531	$84,092	$109,320	$134,548
	Occupational Therapist Assistant	308	623	$64,165	$83,414	$102,664
	Office Clerk	301	335	$47,840	$56,212	$64,584
	OneCare Operations Manager	315	461	$109,892	$142,859	$175,827
	OneCare Partner - Sales	305	230	$55,966	$69,958	$83,949
	OneCare Partner - Sales (Lead)	307	537	$60,533	$77,179	$93,826
	OneCare Partner - Service	301	231	$47,840	$56,212	$64,584
	OneCare Partner (Inside Sales)	303	371	$51,744	$62,092	$72,441
	Outreach Specialist	301	218	$47,840	$56,212	$64,584
	Paralegal/Legal Secretary	308	376	$64,165	$83,414	$102,664
	Payroll Specialist	304	554	$53,813	$67,267	$80,720
	Payroll Specialist Sr	306	688	$58,205	$74,211	$90,217
	Performance Analyst	308	538	$64,165	$83,414	$102,664
	Personal Care Attendant	301	485	$47,840	$56,212	$64,584
	Personal Care Attendant - Lead	302	498	$49,754	$59,704	$69,655
	Personal Care Coordinator	303	525	$51,744	$62,092	$72,441
	Personal Care Coordinator Sr	304	689	$53,813	$67,267	$80,720
	Pharmacy Resident	305	379	$55,966	$69,958	$83,949

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Pharmacy Services Specialist	301	23	$47,840	$56,212	$64,584
Pharmacy Services Specialist Int	302	35	$49,754	$59,704	$69,655
Pharmacy Services Specialist Sr	304	507	$53,813	$67,267	$80,720
Physical Therapist	312	530	$84,092	$109,320	$134,548
Physical Therapist Assistant	308	624	$64,165	$83,414	$102,664
Policy Advisor Sr	312	580	$84,092	$109,320	$134,548
Principal Financial Analyst	315	907	$109,892	$142,859	$175,827
Privacy Manager	315	536	$109,892	$142,859	$175,827
Privacy Officer	315	648	$109,892	$142,859	$175,827
Process Excellence Manager I	307	930	$60,533	$77,179	$93,826
Process Excellence Manager II	310	931	$72,096	$93,724	$115,353
Process Excellence Manager III	313	932	$90,820	$118,066	$145,312
Process Excellence Manager IV	315	933	$109,892	$142,859	$175,827
Program Assistant	302	24	$49,754	$59,704	$69,655
Program Coordinator	303	284	$51,744	$62,092	$72,441
Program Development Analyst Sr	311	492	$77,863	$101,222	$124,581
Program Manager	311	421	$77,863	$101,222	$124,581
Program Manager Sr	313	594	$90,820	$118,066	$145,312
Program Specialist	305	36	$55,966	$69,958	$83,949
Program Specialist Int	307	61	$60,533	$77,179	$93,826
Program Specialist Sr	309	508	$68,015	$88,419	$108,824
Program/Policy Analyst	309	56	$68,015	$88,419	$108,824
Program/Policy Analyst Sr	311	85	$77,863	$101,222	$124,581
Programmer	310	43	$72,096	$93,724	$115,353
Programmer Int	313	74	$90,820	$118,066	$145,312
Programmer Sr	314	80	$99,902	$129,872	$159,843
Project Manager I	308	934	$64,165	$83,414	$102,664
Project Manager II	312	935	$84,092	$109,320	$134,548
Project Manager III	315	936	$109,892	$142,859	$175,827
Project Manager IV	316	937	$120,881	$157,145	$193,410
Project Specialist	304	291	$53,813	$67,267	$80,720
Provider Data Management Services Coordinator	303	12	$51,744	$62,092	$72,441
Provider Data Management Services Coordinator Sr	305	586	$55,966	$69,958	$83,949
Provider Enrollment Manager	306	190	$58,205	$74,211	$90,217
Provider Network Rep Sr	308	391	$64,165	$83,414	$102,664
Provider Network Specialist	307	44	$60,533	$77,179	$93,826
Provider Network Specialist Sr	309	595	$68,015	$88,419	$108,824
Provider Office Education Manager	307	300	$60,533	$77,179	$93,826
Provider Relations Rep	306	205	$58,205	$74,211	$90,217
Provider Relations Rep Sr	308	285	$64,165	$83,414	$102,664
Publications Coordinator	306	293	$58,205	$74,211	$90,217
QA Analyst	309	486	$68,015	$88,419	$108,824

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QA Analyst Sr	312	380	$84,092	$109,320	$134,548
QA Test Automation Engineer	310	938	$72,096	$93,724	$115,353
QA Test Automation Engineer Advisor	315	939	$109,892	$142,859	$175,827
QA Test Automation Engineer Sr.	314	940	$99,902	$129,872	$159,843
QI Nurse Specialist	313	82	$90,820	$118,066	$145,312
QI Nurse Specialist (LVN)	312	445	$84,092	$109,320	$134,548
Quality Improvement Specialist	309	982	$68,015	$88,419	$108,824
Quality Improvement Specialist Sr	311	983	$77,863	$101,222	$124,581
Receptionist	301	140	$47,840	$56,212	$64,584
Records Manager	317	778	$132,969	$172,860	$212,751
Recreational Therapist	306	487	$58,205	$74,211	$90,217
Registered Dietitian	310	57	$72,096	$93,724	$115,353
Regulatory Affairs and Compliance - Lead	311	630	$77,863	$101,222	$124,581
Regulatory Affairs and Compliance Analyst	309	628	$68,015	$88,419	$108,824
Regulatory Affairs and Compliance Analyst Sr	310	629	$72,096	$93,724	$115,353
RN (PACE)	313	480	$90,820	$118,066	$145,312
Security Officer	301	311	$47,840	$56,212	$64,584
Service Desk Technician	304	571	$53,813	$67,267	$80,720
Service Desk Technician Sr	305	573	$55,966	$69,958	$83,949
SharePoint Developer/Administrator Sr	314	397	$99,902	$129,872	$159,843
Social Worker	309	463	$68,015	$88,419	$108,824
Social Worker Sr	310	690	$72,096	$93,724	$115,353
Speech Therapist	312	941	$84,092	$109,320	$134,548
* Sr Director	324	896	$216,737	$281,757	$346,778
Sr Manager I	316	897	$120,881	$157,145	$193,410
Sr Manager II	317	898	$132,969	$172,860	$212,751
Sr Manager III	318	899	$146,266	$190,146	$234,026
Sr Manager IV	319	900	$160,893	$209,160	$257,428
Supervisor Accounting	314	434	$99,902	$129,872	$159,843
Supervisor Audit and Oversight	313	618	$90,820	$118,066	$145,312
Supervisor Behavioral Health	313	659	$90,820	$118,066	$145,312
Supervisor Budgeting	314	466	$99,902	$129,872	$159,843
Supervisor Case Management	315	86	$109,892	$142,859	$175,827
Supervisor Claims	312	219	$84,092	$109,320	$134,548
Supervisor Coding Initiatives	313	502	$90,820	$118,066	$145,312
Supervisor Credentialing	308	671	$64,165	$83,414	$102,664
Supervisor Customer Service	308	34	$64,165	$83,414	$102,664
Supervisor Data Entry	306	192	$58,205	$74,211	$90,217
Supervisor Day Center (PACE)	306	619	$58,205	$74,211	$90,217
Supervisor Dietary Services (PACE)	312	643	$84,092	$109,320	$134,548
Supervisor Encounters	307	253	$60,533	$77,179	$93,826
Supervisor Facilities	310	162	$72,096	$93,724	$115,353

Annual Base Salary Schedule

Revised and Approved by CalOptima Health Board of Directors: May 2, 2024

Schedule Effective Date/To Be Implemented: May 5, 2024

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Finance	314	419	$99,902	$129,872	$159,843
Supervisor Grievance and Appeals	312	620	$84,092	$109,320	$134,548
Supervisor Information Technology Services	314	457	$99,902	$129,872	$159,843
Supervisor Long Term Support Services	315	587	$109,892	$142,859	$175,827
Supervisor Medical Assistant	306	984	$58,205	$74,211	$90,217
Supervisor Member Outreach and Education	311	592	$77,863	$101,222	$124,581
Supervisor MSSP	314	348	$99,902	$129,872	$159,843
Supervisor Nursing Services (PACE)	315	662	$109,892	$142,859	$175,827
Supervisor OneCare Customer Service	308	408	$64,165	$83,414	$102,664
Supervisor Payroll	313	517	$90,820	$118,066	$145,312
Supervisor Pharmacist	317	610	$132,969	$172,860	$212,751
Supervisor Population Health Management	313	673	$90,820	$118,066	$145,312
Supervisor Provider Data Management Services	311	439	$77,863	$101,222	$124,581
Supervisor Provider Relations	312	652	$84,092	$109,320	$134,548
Supervisor Quality Analytics	313	609	$90,820	$118,066	$145,312
Supervisor Quality Improvement	313	600	$90,820	$118,066	$145,312
Supervisor Regulatory Affairs and Compliance	313	627	$90,820	$118,066	$145,312
Supervisor Social Work (PACE)	313	636	$90,820	$118,066	$145,312
Supervisor Therapy Services (PACE)	314	645	$99,902	$129,872	$159,843
Supervisor Utilization Management	315	637	$109,892	$142,859	$175,827
Systems Operations Analyst	304	32	$53,813	$67,267	$80,720
Systems Operations Analyst Int	307	45	$60,533	$77,179	$93,826
Technical Analyst Int	309	64	$68,015	$88,419	$108,824
Technical Analyst Sr	312	75	$84,092	$109,320	$134,548
Technical Support Specialist Sr	307	942	$60,533	$77,179	$93,826
Telephony Engineer	314	943	$99,902	$129,872	$159,843
Telephony Engineer Sr	316	944	$120,881	$157,145	$193,410
Therapy Aide	304	521	$53,813	$67,267	$80,720
Training Administrator	308	621	$64,165	$83,414	$102,664
Training Program Coordinator	306	471	$58,205	$74,211	$90,217
Translation Specialist	305	241	$55,966	$69,958	$83,949
Web Architect	314	366	$99,902	$129,872	$159,843

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Policy: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: */s/*

Effective Date: 05/01/2014
Revised Date: 05/04/2023

Applicable to:
☐ Medi-Cal
☐ OneCare
☐ PACE
☒ Administrative

For 20240801 Review Only

I. PURPOSE

A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima Health has established the attached salary schedule for each CalOptima Health job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Chief Human Resources Officer (CHRO) to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health - Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 05/04/2023; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 Review Only

Date	Meeting
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative

For 20240801 Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	12/01/2022	GA.8058	Salary Schedule	Administrative
Revised	05/04/2023	GA.8058	Salary Schedule	Administrative

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For 20240801 Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
4

For 20240801 Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	05/04/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20240801 Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications
4 including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate
5 amounts).
6
7 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
8 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
9 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
10 pension calculation under CalPERS regulations.
11
12 **II. POLICY**
13
14 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
15 CalOptima Health has established the attached salary schedule for each CalOptima Health job
16 position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human
17 Resources Department (HR) shall maintain a salary schedule that meets the following eight (8)
18 separate criteria:
19
20 1. Approval and adoption by the governing body in accordance with requirements applicable to
21 public meetings laws;
22
23 2. Identification of position titles for every employee position;
24
25 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
26 multiple amounts with a range;
27
28 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
29 bi-weekly, monthly, bi-monthly, or annually;
30
31 5. Posted at the employer's office or immediately accessible and available for public review
32 from the employer during normal business hours or posted on the employer's internet
33 website;
34
35 6. Indicates the effective date and date of any revisions;
36

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

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IV. ATTACHMENT(S)

A. CalOptima Health - Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 05/04/2023; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
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12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 Review Only

Date	Meeting
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
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1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
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Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
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Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative

For 20240801 Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
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Revised	12/01/2022	GA.8058	Salary Schedule	Administrative
Revised	05/04/2023	GA.8058	Salary Schedule	Administrative

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For 20240801 Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
4

For 20240801 Review Only

Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: May 4, 2023

Schedule Effective Date/To bBe iImplemented: May 7, 2023

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	H	39	$59,000	$74,391	$89,782
	Accountant II	J	634	$65,000	$85,553	$106,106
	Accountant III	K	68	$70,000	$92,134	$114,268
	Accountant IV	M	908	$85,000	$113,043	$141,086
	Accounting Clerk	D	334	$44,000	$55,814	$67,628
	Accounting Clerk Sr	E	680	$48,000	$60,146	$72,292
	Activity Coordinator (PACE)	E	681	$48,000	$60,146	$72,292
	Actuarial Analyst	K	558	$70,000	$92,134	$114,268
	Actuarial Analyst Sr	L	559	$77,000	$102,047	$127,094
	Actuary	O	357	$105,000	$139,367	$173,734
	Actuary Principal	Q	882	$130,000	$172,272	$214,544
	Actuary Sr	P	883	$117,000	$154,695	$192,390
	Administrative Assistant	D	19	$44,000	$55,814	$67,628
	Administrative Fellow	J	902	$65,000	$85,553	$106,106
	Analyst	H	562	$59,000	$74,391	$89,782
	Analyst Int	I	563	$61,000	$80,055	$99,110
	Analyst Sr	J	564	$65,000	$85,553	$106,106
	Applications Analyst	I	232	$61,000	$80,055	$99,110
	Applications Analyst Int	J	233	$65,000	$85,553	$106,106
	Applications Analyst Sr	L	298	$77,000	$102,047	$127,094
	Associate Director I	P	884	$117,000	$154,695	$192,390
	Associate Director II	Q	885	$130,000	$172,272	$214,544
	Associate Director III	R	886	$144,000	$190,932	$237,864
	Associate Director IV	S	887	$154,000	$212,256	$270,512
	Auditor	I	565	$61,000	$80,055	$99,110
	Auditor Sr	J	566	$65,000	$85,553	$106,106
	Batch Automation Analyst	J	909	$65,000	$85,553	$106,106
	Batch Automation Analyst Sr	K	910	$70,000	$92,134	$114,268
	Biostatistics Manager	M	418	$85,000	$113,043	$141,086
	Business Analyst	J	40	$65,000	$85,553	$106,106
	Business Analyst Sr	L	611	$77,000	$102,047	$127,094
	Business Systems Analyst Sr	K	69	$70,000	$92,134	$114,268
	Buyer	G	29	$55,000	$68,893	$82,786
	Buyer Int	I	49	$61,000	$80,055	$99,110
	Buyer Sr	L	67	$77,000	$102,047	$127,094
	Care Manager	K	657	$70,000	$92,134	$114,268
	Care Transition Intervention Coach (RN)	L	417	$77,000	$102,047	$127,094
	Certified Coder	H	399	$59,000	$74,391	$89,782
	Certified Coding Specialist	H	639	$59,000	$74,391	$89,782
	Certified Coding Specialist Sr	J	640	$65,000	$85,553	$106,106
	Change Control Administrator	I	499	$61,000	$80,055	$99,110
	Change Control Administrator Int	J	500	$65,000	$85,553	$106,106
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900

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Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: May 4, 2023

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: May 7, 2023

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
**	Chief Strategy Officer	W	911	$313,000	$414,450	$515,900
	Claims - Lead	G	574	$55,000	$68,893	$82,786
	Claims Examiner	C	9	$43,281	$52,540	$61,798
	Claims Examiner - Lead	G	236	$55,000	$68,893	$82,786
	Claims Examiner Sr	E	20	$48,000	$60,146	$72,292
	Claims QA Analyst	F	28	$51,000	$64,561	$78,122
	Claims QA Analyst Sr	G	540	$55,000	$68,893	$82,786
	Claims Recovery Specialist	F	283	$51,000	$64,561	$78,122
	Claims Resolution Specialist	F	262	$51,000	$64,561	$78,122
	Clerk of the Board	O	59	$105,000	$139,367	$173,734
	Clinical Auditor	L	567	$77,000	$102,047	$127,094
	Clinical Auditor Sr	M	568	$85,000	$113,043	$141,086
	Clinical Documentation Specialist (RN)	M	641	$85,000	$113,043	$141,086
	Clinical Pharmacist	P	297	$117,000	$154,695	$192,390
	Clinical Systems Administrator	K	607	$70,000	$92,134	$114,268
	Clinical Trainer	M	903	$85,000	$113,043	$141,086
	Clinical Trainer (LVN)	L	904	$77,000	$102,047	$127,094
	Clinician (Behavioral Health)	K	513	$70,000	$92,134	$114,268
	Clinician Sr (Behavioral Health)	L	TBD	$77,000	$102,047	$127,094
	Cloud Engineer	O	912	$105,000	$139,367	$173,734
	Cloud Engineer Sr	P	913	$117,000	$154,695	$192,390
	Communications Specialist	G	188	$55,000	$68,893	$82,786
	Communications Specialist - Lead	J	707	$65,000	$85,553	$106,106
	Communications Specialist Sr	H	708	$59,000	$74,391	$89,782
	Community Partner	H	575	$59,000	$74,391	$89,782
	Community Partner Sr	I	612	$61,000	$80,055	$99,110
	Community Relations Specialist	G	288	$55,000	$68,893	$82,786
	Community Relations Specialist Sr	I	646	$61,000	$80,055	$99,110
	Compliance Claims Auditor	G	222	$55,000	$68,893	$82,786
	Compliance Claims Auditor Sr	H	279	$59,000	$74,391	$89,782
	Contract Administrator	L	385	$77,000	$102,047	$127,094
	Contracts Manager	M	207	$85,000	$113,043	$141,086
	Contracts Manager Sr	N	683	$95,000	$125,039	$155,078
	Contracts Specialist	I	257	$61,000	$80,055	$99,110
	Contracts Specialist Int	J	469	$65,000	$85,553	$106,106

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Contracts Specialist Sr	K	331	$70,000	$92,134	$114,268
*	Controller	T	464	$182,000	$249,576	$317,152
	Credentialing Coordinator	E	41	$48,000	$60,146	$72,292
	Credentialing Coordinator - Lead	F	510	$51,000	$64,561	$78,122
	Customer Service Coordinator	E	182	$48,000	$60,146	$72,292
	Customer Service Rep	C	5	$43,281	$52,540	$61,798
	Customer Service Rep - Lead	G	482	$55,000	$68,893	$82,786
	Customer Service Rep Sr	D	481	$44,000	$55,814	$67,628
	Cybersecurity Analyst	I	914	$61,000	$80,055	$99,110
	Cybersecurity Engineer	O	915	$105,000	$139,367	$173,734
	Cybersecurity Engineer Sr	Q	916	$130,000	$172,272	$214,544
	Cybersecurity Principal	S	917	$154,000	$212,256	$270,512
	Data Analyst	J	337	$65,000	$85,553	$106,106
	Data Analyst Int	K	341	$70,000	$92,134	$114,268
	Data Analyst Sr	L	342	$77,000	$102,047	$127,094
	Data and Reporting Analyst - Lead	M	654	$85,000	$113,043	$141,086
	Data Entry Tech	A	3	$41,600	$47,618	$53,636
	Data Warehouse Architect	N	363	$95,000	$125,039	$155,078
	Data Warehouse Programmer/Analyst	N	364	$95,000	$125,039	$155,078
	Data Warehouse Reporting Analyst	M	412	$85,000	$113,043	$141,086
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$125,039	$155,078
	Database Administrator	L	90	$77,000	$102,047	$127,094
	Database Administrator Sr	N	179	$95,000	$125,039	$155,078
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Designer	K	387	$70,000	$92,134	$114,268
	Designer Sr	L	901	$77,000	$102,047	$127,094
*	Director I	Q	891	$130,000	$172,272	$214,544
*	Director II	R	892	$144,000	$190,932	$237,864
*	Director III	S	893	$154,000	$212,256	$270,512
*	Director IV	T	894	$182,000	$249,576	$317,152
	Enrollment Coordinator (PACE)	F	441	$51,000	$64,561	$78,122
	Enterprise Analytics Manager	O	582	$105,000	$139,367	$173,734
	Executive Administrative Services Manager	J	661	$65,000	$85,553	$106,106
	Executive Assistant	G	339	$55,000	$68,893	$82,786
	Executive Assistant to CEO	I	261	$61,000	$80,055	$99,110
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$68,893	$82,786
	Facilities & Support Services Coordinator	E	10	$48,000	$60,146	$72,292
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$64,561	$78,122
	Facilities Coordinator	E	438	$48,000	$60,146	$72,292
	Financial Analyst I	J	51	$65,000	$85,553	$106,106
	Financial Analyst II	L	84	$77,000	$102,047	$127,094
	Financial Analyst III	M	905	$85,000	$113,043	$141,086

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Financial Analyst IV	N	906	$95,000	$125,039	$155,078
Financial Reporting Analyst	I	475	$61,000	$80,055	$99,110
Grievance & Appeals Nurse Specialist	M	226	$85,000	$113,043	$141,086
Grievance Resolution Specialist	F	42	$51,000	$64,561	$78,122
Grievance Resolution Specialist - Lead	I	590	$61,000	$80,055	$99,110
Grievance Resolution Specialist Sr	H	589	$59,000	$74,391	$89,782
Health Coach	K	556	$70,000	$92,134	$114,268
Health Educator	H	47	$59,000	$74,391	$89,782
Health Educator Sr	I	355	$61,000	$80,055	$99,110
Health Network Liaison Specialist (RN)	L	524	$77,000	$102,047	$127,094
Health Network Oversight Specialist	K	323	$70,000	$92,134	$114,268
HEDIS Case Manager	M	443	$85,000	$113,043	$141,086
Human Resources Assistant	D	181	$44,000	$55,814	$67,628
Human Resources Business Partner	M	584	$85,000	$113,043	$141,086
Human Resources Coordinator	F	316	$51,000	$64,561	$78,122
Human Resources Representative	J	278	$65,000	$85,553	$106,106
Human Resources Representative Sr	L	350	$77,000	$102,047	$127,094
Human Resources Specialist	G	505	$55,000	$68,893	$82,786
Human Resources Specialist Sr	H	608	$59,000	$74,391	$89,782
Information Technology Services Coordinator	E	365	$48,000	$60,146	$72,292
Inpatient Quality Coding Auditor	I	642	$61,000	$80,055	$99,110
Intern	A	237	$41,600	$47,618	$53,636
Investigator	I	TBD	$61,000	$80,055	$99,110
Investigator Sr	K	553	$70,000	$92,134	$114,268
ITS Administrator	L	63	$77,000	$102,047	$127,094
ITS Administrator Sr	M	89	$85,000	$113,043	$141,086
ITS Analyst	I	918	$61,000	$80,055	$99,110
ITS Analyst Int	L	919	$77,000	$102,047	$127,094
ITS Analyst Sr	N	920	$95,000	$125,039	$155,078
ITS Architect II	O	921	$105,000	$139,367	$173,734
ITS Architect III	P	922	$117,000	$154,695	$192,390
ITS Architect IV	Q	923	$130,000	$172,272	$214,544
ITS Developer Advisor	O	924	$105,000	$139,367	$173,734
ITS Product Manager	N	925	$95,000	$125,039	$155,078
ITS Product Manager Sr	O	926	$105,000	$139,367	$173,734
Kitchen Assistant	A	585	$41,600	$47,618	$53,636
Licensed Clinical Social Worker	J	598	$65,000	$85,553	$106,106
Litigation Support Specialist	K	588	$70,000	$92,134	$114,268
LVN (PACE)	K	533	$70,000	$92,134	$114,268
LVN Specialist	K	686	$70,000	$92,134	$114,268
Mailroom Clerk	A	1	$41,600	$47,618	$53,636
Manager Accounting	O	98	$105,000	$139,367	$173,734
Manager Actuary	R	453	$144,000	$190,932	$237,864

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Manager Audit & Oversight	O	539	$105,000	$139,367	$173,734
Manager Behavioral Health	O	633	$105,000	$139,367	$173,734
Manager Business Integration	O	544	$105,000	$139,367	$173,734
Manager Case Management	P	270	$117,000	$154,695	$192,390
Manager Claims	O	92	$105,000	$139,367	$173,734
Manager Clinic Operations	O	551	$105,000	$139,367	$173,734
Manager Clinical Pharmacist	R	296	$144,000	$190,932	$237,864
Manager Coding Quality	N	382	$95,000	$125,039	$155,078
Manager Communications	N	398	$95,000	$125,039	$155,078
Manager Community Relations	N	384	$95,000	$125,039	$155,078
Manager Contracting	O	329	$105,000	$139,367	$173,734
Manager Cultural & Linguistic	M	349	$85,000	$113,043	$141,086
Manager Customer Service	M	94	$85,000	$113,043	$141,086
Manager Electronic Business	N	422	$95,000	$125,039	$155,078
Manager Encounters	N	516	$95,000	$125,039	$155,078
Manager Environmental Health & Safety	N	495	$95,000	$125,039	$155,078
Manager Finance	O	148	$105,000	$139,367	$173,734
Manager Financial Analysis	P	356	$117,000	$154,695	$192,390
Manager Government Affairs	N	437	$95,000	$125,039	$155,078
Manager Grievance & Appeals	O	426	$105,000	$139,367	$173,734
Manager Human Resources	O	526	$105,000	$139,367	$173,734
Manager Information Technology Services	P	560	$117,000	$154,695	$192,390
Manager Long Term Support Services	P	200	$117,000	$154,695	$192,390
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$125,039	$155,078
Manager Member Liaison Program	M	354	$85,000	$113,043	$141,086
Manager Member Outreach & Education	M	616	$85,000	$113,043	$141,086
Manager MSSP	O	393	$105,000	$139,367	$173,734
Manager OneCare Clinical	P	359	$117,000	$154,695	$192,390
Manager OneCare Customer Service	M	429	$85,000	$113,043	$141,086
Manager Outreach & Enrollment	M	477	$85,000	$113,043	$141,086
Manager PACE Center	O	432	$105,000	$139,367	$173,734
Manager Population Health Management	N	674	$95,000	$125,039	$155,078
Manager Process Excellence	O	622	$105,000	$139,367	$173,734
Manager Program Implementation	N	488	$95,000	$125,039	$155,078
Manager Provider Data Management Services	M	653	$85,000	$113,043	$141,086
Manager Provider Network	O	191	$105,000	$139,367	$173,734
Manager Provider Relations	M	171	$85,000	$113,043	$141,086
Manager Purchasing	O	275	$105,000	$139,367	$173,734
Manager QI Initiatives	M	433	$85,000	$113,043	$141,086
Manager Quality Analytics	N	617	$95,000	$125,039	$155,078
Manager Quality Improvement	N	104	$95,000	$125,039	$155,078
Manager Regulatory Affairs and Compliance	O	626	$105,000	$139,367	$173,734
Manager Reporting & Financial Compliance	O	572	$105,000	$139,367	$173,734

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Strategic Development	O	603	$105,000	$139,367	$173,734
	Manager Utilization Management	P	250	$117,000	$154,695	$192,390
	Marketing and Outreach Specialist	G	496	$55,000	$68,893	$82,786
	Marketing and Outreach Specialist Sr	I	TBD	$61,000	$80,055	$99,110
	Medical Assistant	C	535	$43,281	$52,540	$61,798
	Medical Authorization Asst	C	11	$43,281	$52,540	$61,798
	Medical Case Manager	L	72	$77,000	$102,047	$127,094
	Medical Case Manager (LVN)	K	444	$70,000	$92,134	$114,268
*	Medical Director	V	306	$266,000	$365,034	$464,068
	Medical Records & Health Plan Assistant	B	548	$42,432	$50,366	$58,300
	Medical Records Clerk	B	523	$42,432	$50,366	$58,300
	Medical Services Case Manager	G	54	$55,000	$68,893	$82,786
	Member Liaison Specialist	D	353	$44,000	$55,814	$67,628
	Member Liaison Specialist Sr	E	TBD	$48,000	$60,146	$72,292
	MMS Program Coordinator	G	360	$55,000	$68,893	$82,786
	Network Engineer	N	927	$95,000	$125,039	$155,078
	Network Engineer Principal	Q	928	$130,000	$172,272	$214,544
	Network Engineer Sr	O	929	$105,000	$139,367	$173,734
	Nurse Practitioner (PACE)	O	635	$105,000	$139,367	$173,734
	Occupational Therapist	L	531	$77,000	$102,047	$127,094
	Occupational Therapist Assistant	H	623	$59,000	$74,391	$89,782
	Office Clerk	A	335	$41,600	$47,618	$53,636
	OneCare Operations Manager	N	461	$95,000	$125,039	$155,078
	OneCare Partner - Sales	F	230	$51,000	$64,561	$78,122
	OneCare Partner - Sales (Lead)	G	537	$55,000	$68,893	$82,786
	OneCare Partner - Service	C	231	$43,281	$52,540	$61,798
	OneCare Partner (Inside Sales)	E	371	$48,000	$60,146	$72,292
	Outreach Specialist	C	218	$43,281	$52,540	$61,798
	Paralegal/Legal Secretary	I	376	$61,000	$80,055	$99,110
	Payroll Specialist	E	554	$48,000	$60,146	$72,292
	Payroll Specialist Sr	G	688	$55,000	$68,893	$82,786
	Performance Analyst	I	538	$61,000	$80,055	$99,110
	Personal Care Attendant	A	485	$41,600	$47,618	$53,636
	Personal Care Attendant - Lead	B	498	$42,432	$50,366	$58,300
	Personal Care Coordinator	C	525	$43,281	$52,540	$61,798
	Personal Care Coordinator Sr	D	689	$44,000	$55,814	$67,628
	Pharmacy Resident	G	379	$55,000	$68,893	$82,786
	Pharmacy Services Specialist	C	23	$43,281	$52,540	$61,798
	Pharmacy Services Specialist Int	D	35	$44,000	$55,814	$67,628
	Pharmacy Services Specialist Sr	E	507	$48,000	$60,146	$72,292
	Physical Therapist	L	530	$77,000	$102,047	$127,094
	Physical Therapist Assistant	H	624	$59,000	$74,391	$89,782
	Policy Advisor Sr	M	580	$85,000	$113,043	$141,086

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Principal Financial Analyst	O	907	$105,000	$139,367	$173,734
Privacy Manager	N	536	$95,000	$125,039	$155,078
Privacy Officer	O	648	$105,000	$139,367	$173,734
Process Excellence Manager I	H	930	$59,000	$74,391	$89,782
Process Excellence Manager II	J	931	$65,000	$85,553	$106,106
Process Excellence Manager III	M	932	$85,000	$113,043	$141,086
Process Excellence Manager IV	O	933	$105,000	$139,367	$173,734
Program Assistant	C	24	$43,281	$52,540	$61,798
Program Coordinator	C	284	$43,281	$52,540	$61,798
Program Development Analyst Sr	K	492	$70,000	$92,134	$114,268
Program Manager	L	421	$77,000	$102,047	$127,094
Program Manager Sr	M	594	$85,000	$113,043	$141,086
Program Specialist	E	36	$48,000	$60,146	$72,292
Program Specialist Int	G	61	$55,000	$68,893	$82,786
Program Specialist Sr	I	508	$61,000	$80,055	$99,110
Program/Policy Analyst	I	56	$61,000	$80,055	$99,110
Program/Policy Analyst Sr	K	85	$70,000	$92,134	$114,268
Programmer	K	43	$70,000	$92,134	$114,268
Programmer Int	M	74	$85,000	$113,043	$141,086
Programmer Sr	N	80	$95,000	$125,039	$155,078
Project Manager I	I	934	$61,000	$80,055	$99,110
Project Manager II	L	935	$77,000	$102,047	$127,094
Project Manager III	O	936	$105,000	$139,367	$173,734
Project Manager IV	P	937	$117,000	$154,695	$192,390
Project Specialist	E	291	$48,000	$60,146	$72,292
Provider Data Management Services Coordinator	D	12	$44,000	$55,814	$67,628
Provider Data Management Services Coordinator Sr	F	586	$51,000	$64,561	$78,122
Provider Enrollment Manager	G	190	$55,000	$68,893	$82,786
Provider Network Rep Sr	I	391	$61,000	$80,055	$99,110
Provider Network Specialist	H	44	$59,000	$74,391	$89,782
Provider Network Specialist Sr	J	595	$65,000	$85,553	$106,106
Provider Office Education Manager	I	300	$61,000	$80,055	$99,110
Provider Relations Rep	G	205	$55,000	$68,893	$82,786
Provider Relations Rep Sr	I	285	$61,000	$80,055	$99,110
Publications Coordinator	G	293	$55,000	$68,893	$82,786
QA Analyst	I	486	$61,000	$80,055	$99,110
QA Analyst Sr	L	380	$77,000	$102,047	$127,094
QA Test Automation Engineer	J	938	$65,000	$85,553	$106,106
QA Test Automation Engineer Advisor	O	939	$105,000	$139,367	$173,734
QA Test Automation Engineer Sr.	N	940	$95,000	$125,039	$155,078
QI Nurse Specialist	M	82	$85,000	$113,043	$141,086
QI Nurse Specialist (LVN)	L	445	$77,000	$102,047	$127,094
Quality Improvement Specialist	I	TBD	$61,000	$80,055	$99,110

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	Quality Improvement Specialist Sr	K	TBD	$70,000	$92,134	$114,268
	Receptionist	B	140	$42,432	$50,366	$58,300
	Records Manager	Q	778	$130,000	$172,272	$214,544
	Recreational Therapist	H	487	$59,000	$74,391	$89,782
	Registered Dietitian	K	57	$70,000	$92,134	$114,268
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$102,047	$127,094
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$80,055	$99,110
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$92,134	$114,268
	RN (PACE)	M	480	$85,000	$113,043	$141,086
	Security Analyst Int	M	534	$85,000	$113,043	$141,086
	Security Analyst Sr	N	474	$95,000	$125,039	$155,078
	Security Officer	B	311	$42,432	$50,366	$58,300
	Service Desk Technician	E	571	$48,000	$60,146	$72,292
	Service Desk Technician Sr	F	573	$51,000	$64,561	$78,122
	SharePoint Developer/Administrator Sr	N	397	$95,000	$125,039	$155,078
	Social Worker	J	463	$65,000	$85,553	$106,106
	Social Worker Sr	K	690	$70,000	$92,134	$114,268
	Speech Therapist	L	941	$77,000	$102,047	$127,094
*	Sr Director	T	896	$182,000	$249,576	$317,152
	Sr Manager I	P	897	$117,000	$154,695	$192,390
	Sr Manager II	Q	898	$130,000	$172,272	$214,544
	Sr Manager III	R	899	$144,000	$190,932	$237,864
	Sr Manager IV	S	900	$154,000	$212,256	$270,512
	Supervisor Accounting	N	434	$95,000	$125,039	$155,078
	Supervisor Audit and Oversight	M	618	$85,000	$113,043	$141,086
	Supervisor Behavioral Health	M	659	$85,000	$113,043	$141,086
	Supervisor Budgeting	N	466	$95,000	$125,039	$155,078
	Supervisor Case Management	N	86	$95,000	$125,039	$155,078
	Supervisor Claims	L	219	$77,000	$102,047	$127,094
	Supervisor Coding Initiatives	M	502	$85,000	$113,043	$141,086
	Supervisor Credentialing	I	671	$61,000	$80,055	$99,110
	Supervisor Customer Service	I	34	$61,000	$80,055	$99,110
	Supervisor Data Entry	H	192	$59,000	$74,391	$89,782
	Supervisor Day Center (PACE)	H	619	$59,000	$74,391	$89,782
	Supervisor Dietary Services (PACE)	L	643	$77,000	$102,047	$127,094
	Supervisor Encounters	I	253	$61,000	$80,055	$99,110
	Supervisor Facilities	J	162	$65,000	$85,553	$106,106
	Supervisor Finance	N	419	$95,000	$125,039	$155,078
	Supervisor Grievance and Appeals	L	620	$77,000	$102,047	$127,094
	Supervisor Information Technology Services	N	457	$95,000	$125,039	$155,078
	Supervisor Long Term Support Services	N	587	$95,000	$125,039	$155,078
	Supervisor Medical Assistant	H	TBD	$59,000	$74,391	$89,782
	Supervisor Member Outreach and Education	K	592	$70,000	$92,134	$114,268

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor MSSP	M	348	$85,000	$113,043	$141,086
Supervisor Nursing Services (PACE)	N	662	$95,000	$125,039	$155,078
Supervisor OneCare Customer Service	I	408	$61,000	$80,055	$99,110
Supervisor Payroll	M	517	$85,000	$113,043	$141,086
Supervisor Pharmacist	Q	610	$130,000	$172,272	$214,544
Supervisor Population Health Management	M	673	$85,000	$113,043	$141,086
Supervisor Provider Data Management Services	K	439	$70,000	$92,134	$114,268
Supervisor Provider Relations	L	652	$77,000	$102,047	$127,094
Supervisor Quality Analytics	M	609	$85,000	$113,043	$141,086
Supervisor Quality Improvement	M	600	$85,000	$113,043	$141,086
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$113,043	$141,086
Supervisor Social Work (PACE)	L	636	$77,000	$102,047	$127,094
Supervisor Therapy Services (PACE)	M	645	$85,000	$113,043	$141,086
Supervisor Utilization Management	N	637	$95,000	$125,039	$155,078
Systems Operations Analyst	F	32	$51,000	$64,561	$78,122
Systems Operations Analyst Int	G	45	$55,000	$68,893	$82,786
Technical Analyst Int	J	64	$65,000	$85,553	$106,106
Technical Analyst Sr	L	75	$77,000	$102,047	$127,094
Technical Support Specialist Sr	I	942	$61,000	$80,055	$99,110
Telephony Engineer	N	943	$95,000	$125,039	$155,078
Telephony Engineer Sr	O	944	$105,000	$139,367	$173,734
Therapy Aide	E	521	$48,000	$60,146	$72,292
Training Administrator	I	621	$61,000	$80,055	$99,110
Training Program Coordinator	H	471	$59,000	$74,391	$89,782
Translation Specialist	B	241	$42,432	$50,366	$58,300
Web Architect	N	366	$95,000	$125,039	$155,078

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: May 4, 2023
Schedule Effective Date/To Be Implemented: May 7, 2023

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	H	39	$59,000	$74,391	$89,782
	Accountant II	J	634	$65,000	$85,553	$106,106
	Accountant III	K	68	$70,000	$92,134	$114,268
	Accountant IV	M	908	$85,000	$113,043	$141,086
	Accounting Clerk	D	334	$44,000	$55,814	$67,628
	Accounting Clerk Sr	E	680	$48,000	$60,146	$72,292
	Activity Coordinator (PACE)	E	681	$48,000	$60,146	$72,292
	Actuarial Analyst	K	558	$70,000	$92,134	$114,268
	Actuarial Analyst Sr	L	559	$77,000	$102,047	$127,094
	Actuary	O	357	$105,000	$139,367	$173,734
	Actuary Principal	Q	882	$130,000	$172,272	$214,544
	Actuary Sr	P	883	$117,000	$154,695	$192,390
	Administrative Assistant	D	19	$44,000	$55,814	$67,628
	Administrative Fellow	J	902	$65,000	$85,553	$106,106
	Analyst	H	562	$59,000	$74,391	$89,782
	Analyst Int	I	563	$61,000	$80,055	$99,110
	Analyst Sr	J	564	$65,000	$85,553	$106,106
	Applications Analyst	I	232	$61,000	$80,055	$99,110
	Applications Analyst Int	J	233	$65,000	$85,553	$106,106
	Applications Analyst Sr	L	298	$77,000	$102,047	$127,094
	Associate Director I	P	884	$117,000	$154,695	$192,390
	Associate Director II	Q	885	$130,000	$172,272	$214,544
	Associate Director III	R	886	$144,000	$190,932	$237,864
	Associate Director IV	S	887	$154,000	$212,256	$270,512
	Auditor	I	565	$61,000	$80,055	$99,110
	Auditor Sr	J	566	$65,000	$85,553	$106,106
	Batch Automation Analyst	J	909	$65,000	$85,553	$106,106
	Batch Automation Analyst Sr	K	910	$70,000	$92,134	$114,268
	Biostatistics Manager	M	418	$85,000	$113,043	$141,086
	Business Analyst	J	40	$65,000	$85,553	$106,106
	Business Analyst Sr	L	611	$77,000	$102,047	$127,094
	Business Systems Analyst Sr	K	69	$70,000	$92,134	$114,268
	Buyer	G	29	$55,000	$68,893	$82,786
	Buyer Int	I	49	$61,000	$80,055	$99,110
	Buyer Sr	L	67	$77,000	$102,047	$127,094
	Care Manager	K	657	$70,000	$92,134	$114,268
	Care Transition Intervention Coach (RN)	L	417	$77,000	$102,047	$127,094
	Certified Coder	H	399	$59,000	$74,391	$89,782
	Certified Coding Specialist	H	639	$59,000	$74,391	$89,782
	Certified Coding Specialist Sr	J	640	$65,000	$85,553	$106,106
	Change Control Administrator	I	499	$61,000	$80,055	$99,110
	Change Control Administrator Int	J	500	$65,000	$85,553	$106,106
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900

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Job Title	Pay Grade	Job Code	Min	Mid	Max
** Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
** Chief Financial Officer	X	134	$368,000	$487,600	$607,200
** Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
** Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
** Chief Information Officer	W	131	$313,000	$414,450	$515,900
** Chief Medical Officer	X	137	$368,000	$487,600	$607,200
** Chief of Staff	U	692	$226,000	$298,900	$371,800
** Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
** Chief Strategy Officer	W	911	$313,000	$414,450	$515,900
Claims - Lead	G	574	$55,000	$68,893	$82,786
Claims Examiner	C	9	$43,281	$52,540	$61,798
Claims Examiner - Lead	G	236	$55,000	$68,893	$82,786
Claims Examiner Sr	E	20	$48,000	$60,146	$72,292
Claims QA Analyst	F	28	$51,000	$64,561	$78,122
Claims QA Analyst Sr	G	540	$55,000	$68,893	$82,786
Claims Recovery Specialist	F	283	$51,000	$64,561	$78,122
Claims Resolution Specialist	F	262	$51,000	$64,561	$78,122
Clerk of the Board	O	59	$105,000	$139,367	$173,734
Clinical Auditor	L	567	$77,000	$102,047	$127,094
Clinical Auditor Sr	M	568	$85,000	$113,043	$141,086
Clinical Documentation Specialist (RN)	M	641	$85,000	$113,043	$141,086
Clinical Pharmacist	P	297	$117,000	$154,695	$192,390
Clinical Systems Administrator	K	607	$70,000	$92,134	$114,268
Clinical Trainer	M	903	$85,000	$113,043	$141,086
Clinical Trainer (LVN)	L	904	$77,000	$102,047	$127,094
Clinician (Behavioral Health)	K	513	$70,000	$92,134	$114,268
Clinician Sr (Behavioral Health)	L	TBD	$77,000	$102,047	$127,094
Cloud Engineer	O	912	$105,000	$139,367	$173,734
Cloud Engineer Sr	P	913	$117,000	$154,695	$192,390
Communications Specialist	G	188	$55,000	$68,893	$82,786
Communications Specialist - Lead	J	707	$65,000	$85,553	$106,106
Communications Specialist Sr	H	708	$59,000	$74,391	$89,782
Community Partner	H	575	$59,000	$74,391	$89,782
Community Partner Sr	I	612	$61,000	$80,055	$99,110
Community Relations Specialist	G	288	$55,000	$68,893	$82,786
Community Relations Specialist Sr	I	646	$61,000	$80,055	$99,110
Compliance Claims Auditor	G	222	$55,000	$68,893	$82,786
Compliance Claims Auditor Sr	H	279	$59,000	$74,391	$89,782
Contract Administrator	L	385	$77,000	$102,047	$127,094
Contracts Manager	M	207	$85,000	$113,043	$141,086
Contracts Manager Sr	N	683	$95,000	$125,039	$155,078
Contracts Specialist	I	257	$61,000	$80,055	$99,110
Contracts Specialist Int	J	469	$65,000	$85,553	$106,106

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Contracts Specialist Sr	K	331	$70,000	$92,134	$114,268
*	Controller	T	464	$182,000	$249,576	$317,152
	Credentialing Coordinator	E	41	$48,000	$60,146	$72,292
	Credentialing Coordinator - Lead	F	510	$51,000	$64,561	$78,122
	Customer Service Coordinator	E	182	$48,000	$60,146	$72,292
	Customer Service Rep	C	5	$43,281	$52,540	$61,798
	Customer Service Rep - Lead	G	482	$55,000	$68,893	$82,786
	Customer Service Rep Sr	D	481	$44,000	$55,814	$67,628
	Cybersecurity Analyst	I	914	$61,000	$80,055	$99,110
	Cybersecurity Engineer	O	915	$105,000	$139,367	$173,734
	Cybersecurity Engineer Sr	Q	916	$130,000	$172,272	$214,544
	Cybersecurity Principal	S	917	$154,000	$212,256	$270,512
	Data Analyst	J	337	$65,000	$85,553	$106,106
	Data Analyst Int	K	341	$70,000	$92,134	$114,268
	Data Analyst Sr	L	342	$77,000	$102,047	$127,094
	Data and Reporting Analyst - Lead	M	654	$85,000	$113,043	$141,086
	Data Entry Tech	A	3	$41,600	$47,618	$53,636
	Data Warehouse Architect	N	363	$95,000	$125,039	$155,078
	Data Warehouse Programmer/Analyst	N	364	$95,000	$125,039	$155,078
	Data Warehouse Reporting Analyst	M	412	$85,000	$113,043	$141,086
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$125,039	$155,078
	Database Administrator	L	90	$77,000	$102,047	$127,094
	Database Administrator Sr	N	179	$95,000	$125,039	$155,078
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Designer	K	387	$70,000	$92,134	$114,268
	Designer Sr	L	901	$77,000	$102,047	$127,094
*	Director I	Q	891	$130,000	$172,272	$214,544
*	Director II	R	892	$144,000	$190,932	$237,864
*	Director III	S	893	$154,000	$212,256	$270,512
*	Director IV	T	894	$182,000	$249,576	$317,152
	Enrollment Coordinator (PACE)	F	441	$51,000	$64,561	$78,122
	Enterprise Analytics Manager	O	582	$105,000	$139,367	$173,734
	Executive Administrative Services Manager	J	661	$65,000	$85,553	$106,106
	Executive Assistant	G	339	$55,000	$68,893	$82,786
	Executive Assistant to CEO	I	261	$61,000	$80,055	$99,110
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$68,893	$82,786
	Facilities & Support Services Coordinator	E	10	$48,000	$60,146	$72,292
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$64,561	$78,122
	Facilities Coordinator	E	438	$48,000	$60,146	$72,292
	Financial Analyst I	J	51	$65,000	$85,553	$106,106
	Financial Analyst II	L	84	$77,000	$102,047	$127,094
	Financial Analyst III	M	905	$85,000	$113,043	$141,086

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Financial Analyst IV	N	906	$95,000	$125,039	$155,078
Financial Reporting Analyst	I	475	$61,000	$80,055	$99,110
Grievance & Appeals Nurse Specialist	M	226	$85,000	$113,043	$141,086
Grievance Resolution Specialist	F	42	$51,000	$64,561	$78,122
Grievance Resolution Specialist - Lead	I	590	$61,000	$80,055	$99,110
Grievance Resolution Specialist Sr	H	589	$59,000	$74,391	$89,782
Health Coach	K	556	$70,000	$92,134	$114,268
Health Educator	H	47	$59,000	$74,391	$89,782
Health Educator Sr	I	355	$61,000	$80,055	$99,110
Health Network Liaison Specialist (RN)	L	524	$77,000	$102,047	$127,094
Health Network Oversight Specialist	K	323	$70,000	$92,134	$114,268
HEDIS Case Manager	M	443	$85,000	$113,043	$141,086
Human Resources Assistant	D	181	$44,000	$55,814	$67,628
Human Resources Business Partner	M	584	$85,000	$113,043	$141,086
Human Resources Coordinator	F	316	$51,000	$64,561	$78,122
Human Resources Representative	J	278	$65,000	$85,553	$106,106
Human Resources Representative Sr	L	350	$77,000	$102,047	$127,094
Human Resources Specialist	G	505	$55,000	$68,893	$82,786
Human Resources Specialist Sr	H	608	$59,000	$74,391	$89,782
Information Technology Services Coordinator	E	365	$48,000	$60,146	$72,292
Inpatient Quality Coding Auditor	I	642	$61,000	$80,055	$99,110
Intern	A	237	$41,600	$47,618	$53,636
Investigator	I	TBD	$61,000	$80,055	$99,110
Investigator Sr	K	553	$70,000	$92,134	$114,268
ITS Administrator	L	63	$77,000	$102,047	$127,094
ITS Administrator Sr	M	89	$85,000	$113,043	$141,086
ITS Analyst	I	918	$61,000	$80,055	$99,110
ITS Analyst Int	L	919	$77,000	$102,047	$127,094
ITS Analyst Sr	N	920	$95,000	$125,039	$155,078
ITS Architect II	O	921	$105,000	$139,367	$173,734
ITS Architect III	P	922	$117,000	$154,695	$192,390
ITS Architect IV	Q	923	$130,000	$172,272	$214,544
ITS Developer Advisor	O	924	$105,000	$139,367	$173,734
ITS Product Manager	N	925	$95,000	$125,039	$155,078
ITS Product Manager Sr	O	926	$105,000	$139,367	$173,734
Kitchen Assistant	A	585	$41,600	$47,618	$53,636
Licensed Clinical Social Worker	J	598	$65,000	$85,553	$106,106
Litigation Support Specialist	K	588	$70,000	$92,134	$114,268
LVN (PACE)	K	533	$70,000	$92,134	$114,268
LVN Specialist	K	686	$70,000	$92,134	$114,268
Mailroom Clerk	A	1	$41,600	$47,618	$53,636
Manager Accounting	O	98	$105,000	$139,367	$173,734
Manager Actuary	R	453	$144,000	$190,932	$237,864

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Manager Audit & Oversight	O	539	$105,000	$139,367	$173,734
Manager Behavioral Health	O	633	$105,000	$139,367	$173,734
Manager Business Integration	O	544	$105,000	$139,367	$173,734
Manager Case Management	P	270	$117,000	$154,695	$192,390
Manager Claims	O	92	$105,000	$139,367	$173,734
Manager Clinic Operations	O	551	$105,000	$139,367	$173,734
Manager Clinical Pharmacist	R	296	$144,000	$190,932	$237,864
Manager Coding Quality	N	382	$95,000	$125,039	$155,078
Manager Communications	N	398	$95,000	$125,039	$155,078
Manager Community Relations	N	384	$95,000	$125,039	$155,078
Manager Contracting	O	329	$105,000	$139,367	$173,734
Manager Cultural & Linguistic	M	349	$85,000	$113,043	$141,086
Manager Customer Service	M	94	$85,000	$113,043	$141,086
Manager Electronic Business	N	422	$95,000	$125,039	$155,078
Manager Encounters	N	516	$95,000	$125,039	$155,078
Manager Environmental Health & Safety	N	495	$95,000	$125,039	$155,078
Manager Finance	O	148	$105,000	$139,367	$173,734
Manager Financial Analysis	P	356	$117,000	$154,695	$192,390
Manager Government Affairs	N	437	$95,000	$125,039	$155,078
Manager Grievance & Appeals	O	426	$105,000	$139,367	$173,734
Manager Human Resources	O	526	$105,000	$139,367	$173,734
Manager Information Technology Services	P	560	$117,000	$154,695	$192,390
Manager Long Term Support Services	P	200	$117,000	$154,695	$192,390
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$125,039	$155,078
Manager Member Liaison Program	M	354	$85,000	$113,043	$141,086
Manager Member Outreach & Education	M	616	$85,000	$113,043	$141,086
Manager MSSP	O	393	$105,000	$139,367	$173,734
Manager OneCare Clinical	P	359	$117,000	$154,695	$192,390
Manager OneCare Customer Service	M	429	$85,000	$113,043	$141,086
Manager Outreach & Enrollment	M	477	$85,000	$113,043	$141,086
Manager PACE Center	O	432	$105,000	$139,367	$173,734
Manager Population Health Management	N	674	$95,000	$125,039	$155,078
Manager Process Excellence	O	622	$105,000	$139,367	$173,734
Manager Program Implementation	N	488	$95,000	$125,039	$155,078
Manager Provider Data Management Services	M	653	$85,000	$113,043	$141,086
Manager Provider Network	O	191	$105,000	$139,367	$173,734
Manager Provider Relations	M	171	$85,000	$113,043	$141,086
Manager Purchasing	O	275	$105,000	$139,367	$173,734
Manager QI Initiatives	M	433	$85,000	$113,043	$141,086
Manager Quality Analytics	N	617	$95,000	$125,039	$155,078
Manager Quality Improvement	N	104	$95,000	$125,039	$155,078
Manager Regulatory Affairs and Compliance	O	626	$105,000	$139,367	$173,734
Manager Reporting & Financial Compliance	O	572	$105,000	$139,367	$173,734

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Strategic Development	O	603	$105,000	$139,367	$173,734
	Manager Utilization Management	P	250	$117,000	$154,695	$192,390
	Marketing and Outreach Specialist	G	496	$55,000	$68,893	$82,786
	Marketing and Outreach Specialist Sr	I	TBD	$61,000	$80,055	$99,110
	Medical Assistant	C	535	$43,281	$52,540	$61,798
	Medical Authorization Asst	C	11	$43,281	$52,540	$61,798
	Medical Case Manager	L	72	$77,000	$102,047	$127,094
	Medical Case Manager (LVN)	K	444	$70,000	$92,134	$114,268
*	Medical Director	V	306	$266,000	$365,034	$464,068
	Medical Records & Health Plan Assistant	B	548	$42,432	$50,366	$58,300
	Medical Records Clerk	B	523	$42,432	$50,366	$58,300
	Medical Services Case Manager	G	54	$55,000	$68,893	$82,786
	Member Liaison Specialist	D	353	$44,000	$55,814	$67,628
	Member Liaison Specialist Sr	E	TBD	$48,000	$60,146	$72,292
	MMS Program Coordinator	G	360	$55,000	$68,893	$82,786
	Network Engineer	N	927	$95,000	$125,039	$155,078
	Network Engineer Principal	Q	928	$130,000	$172,272	$214,544
	Network Engineer Sr	O	929	$105,000	$139,367	$173,734
	Nurse Practitioner (PACE)	O	635	$105,000	$139,367	$173,734
	Occupational Therapist	L	531	$77,000	$102,047	$127,094
	Occupational Therapist Assistant	H	623	$59,000	$74,391	$89,782
	Office Clerk	A	335	$41,600	$47,618	$53,636
	OneCare Operations Manager	N	461	$95,000	$125,039	$155,078
	OneCare Partner - Sales	F	230	$51,000	$64,561	$78,122
	OneCare Partner - Sales (Lead)	G	537	$55,000	$68,893	$82,786
	OneCare Partner - Service	C	231	$43,281	$52,540	$61,798
	OneCare Partner (Inside Sales)	E	371	$48,000	$60,146	$72,292
	Outreach Specialist	C	218	$43,281	$52,540	$61,798
	Paralegal/Legal Secretary	I	376	$61,000	$80,055	$99,110
	Payroll Specialist	E	554	$48,000	$60,146	$72,292
	Payroll Specialist Sr	G	688	$55,000	$68,893	$82,786
	Performance Analyst	I	538	$61,000	$80,055	$99,110
	Personal Care Attendant	A	485	$41,600	$47,618	$53,636
	Personal Care Attendant - Lead	B	498	$42,432	$50,366	$58,300
	Personal Care Coordinator	C	525	$43,281	$52,540	$61,798
	Personal Care Coordinator Sr	D	689	$44,000	$55,814	$67,628
	Pharmacy Resident	G	379	$55,000	$68,893	$82,786
	Pharmacy Services Specialist	C	23	$43,281	$52,540	$61,798
	Pharmacy Services Specialist Int	D	35	$44,000	$55,814	$67,628
	Pharmacy Services Specialist Sr	E	507	$48,000	$60,146	$72,292
	Physical Therapist	L	530	$77,000	$102,047	$127,094
	Physical Therapist Assistant	H	624	$59,000	$74,391	$89,782
	Policy Advisor Sr	M	580	$85,000	$113,043	$141,086

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Principal Financial Analyst	O	907	$105,000	$139,367	$173,734
Privacy Manager	N	536	$95,000	$125,039	$155,078
Privacy Officer	O	648	$105,000	$139,367	$173,734
Process Excellence Manager I	H	930	$59,000	$74,391	$89,782
Process Excellence Manager II	J	931	$65,000	$85,553	$106,106
Process Excellence Manager III	M	932	$85,000	$113,043	$141,086
Process Excellence Manager IV	O	933	$105,000	$139,367	$173,734
Program Assistant	C	24	$43,281	$52,540	$61,798
Program Coordinator	C	284	$43,281	$52,540	$61,798
Program Development Analyst Sr	K	492	$70,000	$92,134	$114,268
Program Manager	L	421	$77,000	$102,047	$127,094
Program Manager Sr	M	594	$85,000	$113,043	$141,086
Program Specialist	E	36	$48,000	$60,146	$72,292
Program Specialist Int	G	61	$55,000	$68,893	$82,786
Program Specialist Sr	I	508	$61,000	$80,055	$99,110
Program/Policy Analyst	I	56	$61,000	$80,055	$99,110
Program/Policy Analyst Sr	K	85	$70,000	$92,134	$114,268
Programmer	K	43	$70,000	$92,134	$114,268
Programmer Int	M	74	$85,000	$113,043	$141,086
Programmer Sr	N	80	$95,000	$125,039	$155,078
Project Manager I	I	934	$61,000	$80,055	$99,110
Project Manager II	L	935	$77,000	$102,047	$127,094
Project Manager III	O	936	$105,000	$139,367	$173,734
Project Manager IV	P	937	$117,000	$154,695	$192,390
Project Specialist	E	291	$48,000	$60,146	$72,292
Provider Data Management Services Coordinator	D	12	$44,000	$55,814	$67,628
Provider Data Management Services Coordinator Sr	F	586	$51,000	$64,561	$78,122
Provider Enrollment Manager	G	190	$55,000	$68,893	$82,786
Provider Network Rep Sr	I	391	$61,000	$80,055	$99,110
Provider Network Specialist	H	44	$59,000	$74,391	$89,782
Provider Network Specialist Sr	J	595	$65,000	$85,553	$106,106
Provider Office Education Manager	I	300	$61,000	$80,055	$99,110
Provider Relations Rep	G	205	$55,000	$68,893	$82,786
Provider Relations Rep Sr	I	285	$61,000	$80,055	$99,110
Publications Coordinator	G	293	$55,000	$68,893	$82,786
QA Analyst	I	486	$61,000	$80,055	$99,110
QA Analyst Sr	L	380	$77,000	$102,047	$127,094
QA Test Automation Engineer	J	938	$65,000	$85,553	$106,106
QA Test Automation Engineer Advisor	O	939	$105,000	$139,367	$173,734
QA Test Automation Engineer Sr.	N	940	$95,000	$125,039	$155,078
QI Nurse Specialist	M	82	$85,000	$113,043	$141,086
QI Nurse Specialist (LVN)	L	445	$77,000	$102,047	$127,094
Quality Improvement Specialist	I	TBD	$61,000	$80,055	$99,110

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: May 4, 2023
Schedule Effective Date/To Be Implemented: May 7, 2023

Job Title	Pay Grade	Job Code	Min	Mid	Max
Quality Improvement Specialist Sr	K	TBD	$70,000	$92,134	$114,268
Receptionist	B	140	$42,432	$50,366	$58,300
Records Manager	Q	778	$130,000	$172,272	$214,544
Recreational Therapist	H	487	$59,000	$74,391	$89,782
Registered Dietitian	K	57	$70,000	$92,134	$114,268
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$102,047	$127,094
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$80,055	$99,110
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$92,134	$114,268
RN (PACE)	M	480	$85,000	$113,043	$141,086
Security Analyst Int	M	534	$85,000	$113,043	$141,086
Security Analyst Sr	N	474	$95,000	$125,039	$155,078
Security Officer	B	311	$42,432	$50,366	$58,300
Service Desk Technician	E	571	$48,000	$60,146	$72,292
Service Desk Technician Sr	F	573	$51,000	$64,561	$78,122
SharePoint Developer/Administrator Sr	N	397	$95,000	$125,039	$155,078
Social Worker	J	463	$65,000	$85,553	$106,106
Social Worker Sr	K	690	$70,000	$92,134	$114,268
Speech Therapist	L	941	$77,000	$102,047	$127,094
* Sr Director	T	896	$182,000	$249,576	$317,152
Sr Manager I	P	897	$117,000	$154,695	$192,390
Sr Manager II	Q	898	$130,000	$172,272	$214,544
Sr Manager III	R	899	$144,000	$190,932	$237,864
Sr Manager IV	S	900	$154,000	$212,256	$270,512
Supervisor Accounting	N	434	$95,000	$125,039	$155,078
Supervisor Audit and Oversight	M	618	$85,000	$113,043	$141,086
Supervisor Behavioral Health	M	659	$85,000	$113,043	$141,086
Supervisor Budgeting	N	466	$95,000	$125,039	$155,078
Supervisor Case Management	N	86	$95,000	$125,039	$155,078
Supervisor Claims	L	219	$77,000	$102,047	$127,094
Supervisor Coding Initiatives	M	502	$85,000	$113,043	$141,086
Supervisor Credentialing	I	671	$61,000	$80,055	$99,110
Supervisor Customer Service	I	34	$61,000	$80,055	$99,110
Supervisor Data Entry	H	192	$59,000	$74,391	$89,782
Supervisor Day Center (PACE)	H	619	$59,000	$74,391	$89,782
Supervisor Dietary Services (PACE)	L	643	$77,000	$102,047	$127,094
Supervisor Encounters	I	253	$61,000	$80,055	$99,110
Supervisor Facilities	J	162	$65,000	$85,553	$106,106
Supervisor Finance	N	419	$95,000	$125,039	$155,078
Supervisor Grievance and Appeals	L	620	$77,000	$102,047	$127,094
Supervisor Information Technology Services	N	457	$95,000	$125,039	$155,078
Supervisor Long Term Support Services	N	587	$95,000	$125,039	$155,078
Supervisor Medical Assistant	H	TBD	$59,000	$74,391	$89,782
Supervisor Member Outreach and Education	K	592	$70,000	$92,134	$114,268

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: May 4, 2023
Schedule Effective Date/To Be Implemented: May 7, 2023

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor MSSP	M	348	$85,000	$113,043	$141,086
Supervisor Nursing Services (PACE)	N	662	$95,000	$125,039	$155,078
Supervisor OneCare Customer Service	I	408	$61,000	$80,055	$99,110
Supervisor Payroll	M	517	$85,000	$113,043	$141,086
Supervisor Pharmacist	Q	610	$130,000	$172,272	$214,544
Supervisor Population Health Management	M	673	$85,000	$113,043	$141,086
Supervisor Provider Data Management Services	K	439	$70,000	$92,134	$114,268
Supervisor Provider Relations	L	652	$77,000	$102,047	$127,094
Supervisor Quality Analytics	M	609	$85,000	$113,043	$141,086
Supervisor Quality Improvement	M	600	$85,000	$113,043	$141,086
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$113,043	$141,086
Supervisor Social Work (PACE)	L	636	$77,000	$102,047	$127,094
Supervisor Therapy Services (PACE)	M	645	$85,000	$113,043	$141,086
Supervisor Utilization Management	N	637	$95,000	$125,039	$155,078
Systems Operations Analyst	F	32	$51,000	$64,561	$78,122
Systems Operations Analyst Int	G	45	$55,000	$68,893	$82,786
Technical Analyst Int	J	64	$65,000	$85,553	$106,106
Technical Analyst Sr	L	75	$77,000	$102,047	$127,094
Technical Support Specialist Sr	I	942	$61,000	$80,055	$99,110
Telephony Engineer	N	943	$95,000	$125,039	$155,078
Telephony Engineer Sr	O	944	$105,000	$139,367	$173,734
Therapy Aide	E	521	$48,000	$60,146	$72,292
Training Administrator	I	621	$61,000	$80,055	$99,110
Training Program Coordinator	H	471	$59,000	$74,391	$89,782
Translation Specialist	B	241	$42,432	$50,366	$58,300
Web Architect	N	366	$95,000	$125,039	$155,078

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Back to Agenda Back to Item

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	12/01/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications
4 including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate
5 amounts).
6
7 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
8 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
9 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
10 pension calculation under CalPERS regulations.
11
12 **II. POLICY**
13
14 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
15 CalOptima Health has established the attached salary schedule for each CalOptima Health job
16 position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human
17 Resources Department (HR) shall maintain a salary schedule that meets the following eight (8)
18 separate criteria:
19
20 1. Approval and adoption by the governing body in accordance with requirements applicable to
21 public meetings laws;
22
23 2. Identification of position titles for every employee position;
24
25 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
26 multiple amounts with a range;
27
28 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
29 bi-weekly, monthly, bi-monthly, or annually;
30
31 5. Posted at the employer's office or immediately accessible and available for public review
32 from the employer during normal business hours or posted on the employer's internet
33 website;
34
35 6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health- Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 12/01/2022; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	12/01/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	12/01/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
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3 A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications
4 including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate
5 amounts).
6
7 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
8 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
9 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
10 pension calculation under CalPERS regulations.
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12 **II. POLICY**
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16 position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human
17 Resources Department (HR) shall maintain a salary schedule that meets the following eight (8)
18 separate criteria:
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20 1. Approval and adoption by the governing body in accordance with requirements applicable to
21 public meetings laws;
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23 2. Identification of position titles for every employee position;
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25 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
26 multiple amounts with a range;
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28 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
29 bi-weekly, monthly, bi-monthly, or annually;
30
31 5. Posted at the employer's office or immediately accessible and available for public review
32 from the employer during normal business hours or posted on the employer's internet
33 website;
34
35 6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health - Annual Base Salary Schedule (Revised and Approved by CalOptima Health Board of Directors: 12/01/2022; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
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10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
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12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
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Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	12/01/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: December 1, 2022

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	H	39	$59,000	$71,850	$84,700
	Accountant II	J	634	$65,000	$82,550	$100,100
	Accountant III	K	68	$70,000	$88,900	$107,800
	Accountant IV	M	TBD	$85,000	$109,050	$133,100
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	902	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Batch Automation Analyst	J	TBD	$65,000	$82,550	$100,100
	Batch Automation Analyst Sr	K	TBD	$70,000	$88,900	$107,800
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	I	49	$61,000	$77,250	$93,500
	Buyer Sr	L	67	$77,000	$98,450	$119,900
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200

Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: December 1, 2022

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
**	Chief Strategy Officer	W	TBD	$313,000	$414,450	$515,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinical Trainer	M	903	$85,000	$109,050	$133,100
	Clinical Trainer (LVN)	L	904	$77,000	$98,450	$119,900
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Cloud Engineer	O	TBD	$105,000	$134,450	$163,900
	Cloud Engineer Sr	P	TBD	$117,000	$149,250	$181,500
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	L	385	$77,000	$98,450	$119,900
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$43,281	$50,790	$58,300

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Customer Service Rep - Lead	G	482	$55,000	$66,550	$78,100
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Cybersecurity Analyst	I	TBD	$61,000	$77,250	$93,500
	Cybersecurity Engineer	O	TBD	$105,000	$134,450	$163,900
	Cybersecurity Engineer Sr	Q	TBD	$130,000	$166,200	$202,400
	Cybersecurity Principal	S	TBD	$154,000	$204,600	$255,200
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$41,600	$46,100	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	901	$77,000	$98,450	$119,900
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	905	$85,000	$109,050	$133,100
	Financial Analyst IV	N	906	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500

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Schedule Effective Date/To bBe iImplemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
Human Resources Assistant	D	181	$44,000	$53,900	$63,800
Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
Human Resources Representative	J	278	$65,000	$82,550	$100,100
Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
Human Resources Specialist	G	505	$55,000	$66,550	$78,100
Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$41,600	$46,100	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
ITS Administrator	L	63	$77,000	$98,450	$119,900
ITS Administrator Sr	M	89	$85,000	$109,050	$133,100
ITS Analyst	I	TBD	$61,000	$77,250	$93,500
ITS Analyst Int	L	TBD	$77,000	$98,450	$119,900
ITS Analyst Sr	N	TBD	$95,000	$120,650	$146,300
ITS Architect II	O	TBD	$105,000	$134,450	$163,900
ITS Architect III	P	TBD	$117,000	$149,250	$181,500
ITS Architect IV	Q	TBD	$130,000	$166,200	$202,400
ITS Developer Advisor	O	TBD	$105,000	$134,450	$163,900
ITS Product Manager	N	TBD	$95,000	$120,650	$146,300
ITS Product Manager Sr	O	TBD	$105,000	$134,450	$163,900
Kitchen Assistant	A	585	$41,600	$46,100	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$41,600	$46,100	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100

Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: December 1, 2022

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900
Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
Manager PACE Center	N	432	$95,000	$120,650	$146,300
Manager Population Health Management	N	674	$95,000	$120,650	$146,300
Manager Process Excellence	O	622	$105,000	$134,450	$163,900
Manager Program Implementation	N	488	$95,000	$120,650	$146,300
Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
Manager Provider Network	O	191	$105,000	$134,450	$163,900
Manager Provider Relations	M	171	$85,000	$109,050	$133,100
Manager Purchasing	O	275	$105,000	$134,450	$163,900
Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
Manager Strategic Development	O	603	$105,000	$134,450	$163,900
Manager Utilization Management	P	250	$117,000	$149,250	$181,500
Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
Medical Assistant	C	535	$43,281	$50,790	$58,300
Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
Medical Case Manager	L	72	$77,000	$98,450	$119,900
Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
* Medical Director	V	306	$266,000	$351,900	$437,800
Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
Medical Records Clerk	B	523	$42,432	$48,716	$55,000
Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
Network Engineer	N	TBD	$95,000	$120,650	$146,300

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Network Engineer Principal	Q	TBD	$130,000	$166,200	$202,400
Network Engineer Sr	O	TBD	$105,000	$134,450	$163,900
Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
Occupational Therapist	L	531	$77,000	$98,450	$119,900
Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
Office Clerk	A	335	$41,600	$46,100	$50,600
OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
Outreach Specialist	C	218	$43,281	$50,790	$58,300
Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
Payroll Specialist	E	554	$48,000	$58,100	$68,200
Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
Performance Analyst	I	538	$61,000	$77,250	$93,500
Personal Care Attendant	A	485	$41,600	$46,100	$50,600
Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Principal Financial Analyst	O	907	$105,000	$134,450	$163,900
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager I	H	TBD	$59,000	$71,850	$84,700
Process Excellence Manager II	J	TBD	$65,000	$82,550	$100,100
Process Excellence Manager III	M	TBD	$85,000	$109,050	$133,100
Process Excellence Manager IV	O	TBD	$105,000	$134,450	$163,900
Program Assistant	C	24	$43,281	$50,790	$58,300
Program Coordinator	C	284	$43,281	$50,790	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Programmer Sr	N	80	$95,000	$120,650	$146,300
	Project Manager I	I	TBD	$61,000	$77,250	$93,500
	Project Manager II	L	TBD	$77,000	$98,450	$119,900
	Project Manager III	O	TBD	$105,000	$134,450	$163,900
	Project Manager IV	P	TBD	$117,000	$149,250	$181,500
	Project Specialist	E	291	$48,000	$58,100	$68,200
	Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
	Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
	Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
	Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
	Provider Network Specialist	H	44	$59,000	$71,850	$84,700
	Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
	Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
	Provider Relations Rep	G	205	$55,000	$66,550	$78,100
	Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
	Publications Coordinator	G	293	$55,000	$66,550	$78,100
	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QA Test Automation Engineer	J	TBD	$65,000	$82,550	$100,100
	QA Test Automation Engineer Advisor	O	TBD	$105,000	$134,450	$163,900
	QA Test Automation Engineer Sr.	N	TBD	$95,000	$120,650	$146,300
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$42,432	$48,716	$55,000
	Records Manager	Q	778	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$42,432	$48,716	$55,000
	Service Desk Technician	E	571	$48,000	$58,100	$68,200
	Service Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
	Speech Therapist	L	TBD	$77,000	$98,450	$119,900
*	Sr Director	T	896	$182,000	$240,600	$299,200
	Sr Manager I	P	897	$117,000	$149,250	$181,500
	Sr Manager II	Q	898	$130,000	$166,200	$202,400
	Sr Manager III	R	899	$144,000	$184,200	$224,400
	Sr Manager IV	S	900	$154,000	$204,600	$255,200
	Supervisor Accounting	N	434	$95,000	$120,650	$146,300

Annual Base Salary Schedule—
Revised and Approved by CalOptima Health Board of Directors: December 1, 2022
Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
Supervisor Case Management	M	86	$85,000	$109,050	$133,100
Supervisor Claims	J	219	$65,000	$82,550	$100,100
Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
Supervisor Encounters	I	253	$61,000	$77,250	$93,500
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	N	419	$95,000	$120,650	$146,300
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Technical Support Specialist Sr	I	TBD	$61,000	$77,250	$93,500
Telephony Engineer	N	TBD	$95,000	$120,650	$146,300
Telephony Engineer Sr	O	TBD	$105,000	$134,450	$163,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

Annual Base Salary Schedule—

Revised and Approved by CalOptima Health Board of Directors: December 1, 2022

Schedule Effective Date/To bBe iImplemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: December 1, 2022
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	H	39	$59,000	$71,850	$84,700
	Accountant II	J	634	$65,000	$82,550	$100,100
	Accountant III	K	68	$70,000	$88,900	$107,800
	Accountant IV	M	TBD	$85,000	$109,050	$133,100
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	902	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Batch Automation Analyst	J	TBD	$65,000	$82,550	$100,100
	Batch Automation Analyst Sr	K	TBD	$70,000	$88,900	$107,800
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	I	49	$61,000	$77,250	$93,500
	Buyer Sr	L	67	$77,000	$98,450	$119,900
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200

Annual Base Salary Schedule
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
**	Chief Strategy Officer	W	TBD	$313,000	$414,450	$515,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinical Trainer	M	903	$85,000	$109,050	$133,100
	Clinical Trainer (LVN)	L	904	$77,000	$98,450	$119,900
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Cloud Engineer	O	TBD	$105,000	$134,450	$163,900
	Cloud Engineer Sr	P	TBD	$117,000	$149,250	$181,500
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	L	385	$77,000	$98,450	$119,900
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$43,281	$50,790	$58,300

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Annual Base Salary Schedule
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Customer Service Rep - Lead	G	482	$55,000	$66,550	$78,100
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Cybersecurity Analyst	I	TBD	$61,000	$77,250	$93,500
	Cybersecurity Engineer	O	TBD	$105,000	$134,450	$163,900
	Cybersecurity Engineer Sr	Q	TBD	$130,000	$166,200	$202,400
	Cybersecurity Principal	S	TBD	$154,000	$204,600	$255,200
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$41,600	$46,100	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	901	$77,000	$98,450	$119,900
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	905	$85,000	$109,050	$133,100
	Financial Analyst IV	N	906	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500

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Annual Base Salary Schedule
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Job Title	Pay Grade	Job Code	Min	Mid	Max
Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
Human Resources Assistant	D	181	$44,000	$53,900	$63,800
Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
Human Resources Representative	J	278	$65,000	$82,550	$100,100
Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
Human Resources Specialist	G	505	$55,000	$66,550	$78,100
Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$41,600	$46,100	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
ITS Administrator	L	63	$77,000	$98,450	$119,900
ITS Administrator Sr	M	89	$85,000	$109,050	$133,100
ITS Analyst	I	TBD	$61,000	$77,250	$93,500
ITS Analyst Int	L	TBD	$77,000	$98,450	$119,900
ITS Analyst Sr	N	TBD	$95,000	$120,650	$146,300
ITS Architect II	O	TBD	$105,000	$134,450	$163,900
ITS Architect III	P	TBD	$117,000	$149,250	$181,500
ITS Architect IV	Q	TBD	$130,000	$166,200	$202,400
ITS Developer Advisor	O	TBD	$105,000	$134,450	$163,900
ITS Product Manager	N	TBD	$95,000	$120,650	$146,300
ITS Product Manager Sr	O	TBD	$105,000	$134,450	$163,900
Kitchen Assistant	A	585	$41,600	$46,100	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$41,600	$46,100	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Customer Service	M	94	$85,000	$109,050	$133,100
	Manager Electronic Business	N	422	$95,000	$120,650	$146,300
	Manager Encounters	N	516	$95,000	$120,650	$146,300
	Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
	Manager Finance	O	148	$105,000	$134,450	$163,900
	Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
	Manager Government Affairs	N	437	$95,000	$120,650	$146,300
	Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
	Manager Human Resources	O	526	$105,000	$134,450	$163,900
	Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
	Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
	Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
	Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
	Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
	Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
	Manager MSSP	O	393	$105,000	$134,450	$163,900
	Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
	Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
	Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
	Manager PACE Center	N	432	$95,000	$120,650	$146,300
	Manager Population Health Management	N	674	$95,000	$120,650	$146,300
	Manager Process Excellence	O	622	$105,000	$134,450	$163,900
	Manager Program Implementation	N	488	$95,000	$120,650	$146,300
	Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
	Manager Provider Network	O	191	$105,000	$134,450	$163,900
	Manager Provider Relations	M	171	$85,000	$109,050	$133,100
	Manager Purchasing	O	275	$105,000	$134,450	$163,900
	Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
	Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
	Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
	Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
	Manager Strategic Development	O	603	$105,000	$134,450	$163,900
	Manager Utilization Management	P	250	$117,000	$149,250	$181,500
	Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
	Medical Assistant	C	535	$43,281	$50,790	$58,300
	Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
	Medical Records Clerk	B	523	$42,432	$48,716	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Network Engineer	N	TBD	$95,000	$120,650	$146,300

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Network Engineer Principal	Q	TBD	$130,000	$166,200	$202,400
Network Engineer Sr	O	TBD	$105,000	$134,450	$163,900
Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
Occupational Therapist	L	531	$77,000	$98,450	$119,900
Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
Office Clerk	A	335	$41,600	$46,100	$50,600
OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
Outreach Specialist	C	218	$43,281	$50,790	$58,300
Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
Payroll Specialist	E	554	$48,000	$58,100	$68,200
Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
Performance Analyst	I	538	$61,000	$77,250	$93,500
Personal Care Attendant	A	485	$41,600	$46,100	$50,600
Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Principal Financial Analyst	O	907	$105,000	$134,450	$163,900
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager I	H	TBD	$59,000	$71,850	$84,700
Process Excellence Manager II	J	TBD	$65,000	$82,550	$100,100
Process Excellence Manager III	M	TBD	$85,000	$109,050	$133,100
Process Excellence Manager IV	O	TBD	$105,000	$134,450	$163,900
Program Assistant	C	24	$43,281	$50,790	$58,300
Program Coordinator	C	284	$43,281	$50,790	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: December 1, 2022
Schedule Effective Date/To Be Implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Programmer Sr	N	80	$95,000	$120,650	$146,300
	Project Manager I	I	TBD	$61,000	$77,250	$93,500
	Project Manager II	L	TBD	$77,000	$98,450	$119,900
	Project Manager III	O	TBD	$105,000	$134,450	$163,900
	Project Manager IV	P	TBD	$117,000	$149,250	$181,500
	Project Specialist	E	291	$48,000	$58,100	$68,200
	Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
	Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
	Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
	Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
	Provider Network Specialist	H	44	$59,000	$71,850	$84,700
	Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
	Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
	Provider Relations Rep	G	205	$55,000	$66,550	$78,100
	Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
	Publications Coordinator	G	293	$55,000	$66,550	$78,100
	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QA Test Automation Engineer	J	TBD	$65,000	$82,550	$100,100
	QA Test Automation Engineer Advisor	O	TBD	$105,000	$134,450	$163,900
	QA Test Automation Engineer Sr.	N	TBD	$95,000	$120,650	$146,300
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$42,432	$48,716	$55,000
	Records Manager	Q	778	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$42,432	$48,716	$55,000
	Service Desk Technician	E	571	$48,000	$58,100	$68,200
	Service Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
	Speech Therapist	L	TBD	$77,000	$98,450	$119,900
*	Sr Director	T	896	$182,000	$240,600	$299,200
	Sr Manager I	P	897	$117,000	$149,250	$181,500
	Sr Manager II	Q	898	$130,000	$166,200	$202,400
	Sr Manager III	R	899	$144,000	$184,200	$224,400
	Sr Manager IV	S	900	$154,000	$204,600	$255,200
	Supervisor Accounting	N	434	$95,000	$120,650	$146,300

Annual Base Salary Schedule
Revised and Approved by CalOptima Health Board of Directors: December 1, 2022
Schedule Effective Date/To Be Implemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
Supervisor Case Management	M	86	$85,000	$109,050	$133,100
Supervisor Claims	J	219	$65,000	$82,550	$100,100
Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
Supervisor Encounters	I	253	$61,000	$77,250	$93,500
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	N	419	$95,000	$120,650	$146,300
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Technical Support Specialist Sr	I	TBD	$61,000	$77,250	$93,500
Telephony Engineer	N	TBD	$95,000	$120,650	$146,300
Telephony Engineer Sr	O	TBD	$105,000	$134,450	$163,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

Annual Base Salary Schedule

Revised and Approved by CalOptima Health Board of Directors: December 1, 2022

Schedule Effective Date/To Be Implemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max

* These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	06/02/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35

7. Retained by the employer and available for public inspection for not less than five (5) years; and
8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 06/02/2022; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	06/02/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35

1 7. Retained by the employer and available for public inspection for not less than five (5) years;
2 and
3 8. Does not reference another document in lieu of disclosing the pay rate.
4
5 B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper
6 to implement the salary schedule for all other employees not inconsistent therewith.
7
8 **III. PROCEDURE**
9
10 A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements
11 above and is available at CalOptima's offices, immediately accessible for public review during
12 normal business hours and posted on CalOptima's internal and external websites.
13
14 B. HR shall retain the salary schedule for not less than five (5) years.
15
16 C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness
17 of the salary schedule to market pay levels.
18
19 D. Any adjustments to the salary schedule will require the Executive Director of HR to make a
20 recommendation to the CEO for approval, with the CEO taking the recommendation to the
21 CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO
22 compensation, shall be effective unless and until approved by the CalOptima Board of Directors.
23
24 **IV. ATTACHMENT(S)**
25
26 A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of
27 Directors: 06/02/2022; Amended 08/01/2024)
28
29 **V. REFERENCE(S)**
30
31 A. Title 2, California Code of Regulations, §570.5
32
33 **VI. REGULATORY AGENCY APPROVAL(S)**
34
35 None to Date
36
37 **VII. BOARD ACTION(S)**
38

Date	**Meeting**
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
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3 Not Applicable
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For 20240801 BOD Review Only

CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: June 02, 2022
Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$71,850	$84,700
	Accountant Int	I	634	$61,000	$77,250	$93,500
	Accountant Sr	K	68	$70,000	$88,900	$107,800
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	TBD	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Board Services Specialist	E	435	$48,000	$58,100	$68,200
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	H	49	$59,000	$71,850	$84,700
	Buyer Sr	I	67	$61,000	$77,250	$93,500
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
Claims QA Analyst	F	28	$51,000	$62,350	$73,700
Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
Clerk of the Board	O	59	$105,000	$134,450	$163,900
Clinical Auditor	L	567	$77,000	$98,450	$119,900
Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
Clincal Trainer	M	TBD	$85,000	$109,050	$133,100
Clincal Trainer (LVN)	L	TBD	$77,000	$98,450	$119,900
Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
Communications Specialist	G	188	$55,000	$66,550	$78,100
Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
Community Partner	G	575	$55,000	$66,550	$78,100
Community Partner Sr	H	612	$59,000	$71,850	$84,700
Community Relations Specialist	G	288	$55,000	$66,550	$78,100
Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
Contract Administrator	K	385	$70,000	$88,900	$107,800
Contracts Manager	M	207	$85,000	$109,050	$133,100
Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
Contracts Specialist	I	257	$61,000	$77,250	$93,500
Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
* Controller	T	464	$182,000	$240,600	$299,200
Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
Customer Service Rep	C	5	$43,281	$50,790	$58,300
Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
Data Analyst	J	337	$65,000	$82,550	$100,100
Data Analyst Int	K	341	$70,000	$88,900	$107,800
Data Analyst Sr	L	342	$77,000	$98,450	$119,900
Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
Data Entry Tech	A	3	$41,600	$46,100	$50,600
Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
Database Administrator	L	90	$77,000	$98,450	$119,900
Database Administrator Sr	N	179	$95,000	$120,650	$146,300
** Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
Designer	K	387	$70,000	$88,900	$107,800
Designer Sr	L	901	$77,000	$98,450	$119,900

	Job Title	Pay Grade	Job Code	Min	Mid	Max
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	TBD	$85,000	$109,050	$133,100
	Financial Analyst IV	N	TBD	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
	Human Resources Specialist	G	505	$55,000	$66,550	$78,100
	Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
	Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
	Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
	Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
	Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
	Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
	Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
	Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
	Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
	Intern	A	237	$41,600	$46,100	$50,600
	Investigator Sr	I	553	$61,000	$77,250	$93,500
	Kitchen Assistant	A	585	$41,600	$46,100	$50,600
	Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
	Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
	LVN (PACE)	K	533	$70,000	$88,900	$107,800

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Job Title	Pay Grade	Job Code	Min	Mid	Max
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$41,600	$46,100	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900
Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
Manager PACE Center	N	432	$95,000	$120,650	$146,300
Manager Population Health Management	N	674	$95,000	$120,650	$146,300
Manager Process Excellence	O	622	$105,000	$134,450	$163,900
Manager Program Implementation	N	488	$95,000	$120,650	$146,300
Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
Manager Provider Network	O	191	$105,000	$134,450	$163,900
Manager Provider Relations	M	171	$85,000	$109,050	$133,100
Manager Purchasing	O	275	$105,000	$134,450	$163,900
Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
Manager Strategic Development	O	603	$105,000	$134,450	$163,900
Manager Utilization Management	P	250	$117,000	$149,250	$181,500
Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700

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CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: June 02, 2022
Schedule Effective Date/To bBe iImplemented: June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Medical Assistant	C	535	$43,281	$50,790	$58,300
	Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
	Medical Records Clerk	B	523	$42,432	$48,716	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
	Office Clerk	A	335	$41,600	$46,100	$50,600
	OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
	OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
	OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
	OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
	OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
	Outreach Specialist	C	218	$43,281	$50,790	$58,300
	Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
	Payroll Specialist	E	554	$48,000	$58,100	$68,200
	Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
	Performance Analyst	I	538	$61,000	$77,250	$93,500
	Personal Care Attendant	A	485	$41,600	$46,100	$50,600
	Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
	Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
	Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
	Pharmacy Resident	G	379	$55,000	$66,550	$78,100
	Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
	Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
	Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
	Physical Therapist	L	530	$77,000	$98,450	$119,900
	Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
	Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
	Principal Financial Analyst	O	TBD	$105,000	$134,450	$163,900
	Privacy Manager	N	536	$95,000	$120,650	$146,300
	Privacy Officer	O	648	$105,000	$134,450	$163,900
	Process Excellence Manager	N	529	$95,000	$120,650	$146,300
	Program Assistant	C	24	$43,281	$50,790	$58,300
	Program Coordinator	C	284	$43,281	$50,790	$58,300
	Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
	Program Manager	L	421	$77,000	$98,450	$119,900
	Program Manager Sr	M	594	$85,000	$109,050	$133,100
	Program Specialist	E	36	$48,000	$58,100	$68,200
	Program Specialist Int	G	61	$55,000	$66,550	$78,100
	Program Specialist Sr	I	508	$61,000	$77,250	$93,500
	Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
	Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
	Programmer	K	43	$70,000	$88,900	$107,800
	Programmer Int	M	74	$85,000	$109,050	$133,100
	Programmer Sr	N	80	$95,000	$120,650	$146,300

Job Title	Pay Grade	Job Code	Min	Mid	Max
Project Manager	L	81	$77,000	$98,450	$119,900
Project Manager - Lead	M	467	$85,000	$109,050	$133,100
Project Manager Sr	N	105	$95,000	$120,650	$146,300
Project Specialist	E	291	$48,000	$58,100	$68,200
Project Specialist Sr	I	503	$61,000	$77,250	$93,500
Projects Analyst	G	254	$55,000	$66,550	$78,100
Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
Provider Network Specialist	H	44	$59,000	$71,850	$84,700
Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
Provider Relations Rep	G	205	$55,000	$66,550	$78,100
Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
Publications Coordinator	G	293	$55,000	$66,550	$78,100
QA Analyst	I	486	$61,000	$77,250	$93,500
QA Analyst Sr	L	380	$77,000	$98,450	$119,900
QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
Receptionist	B	140	$42,432	$48,716	$55,000
Records Manager	Q	778	$130,000	$166,200	$202,400
Recreational Therapist	H	487	$59,000	$71,850	$84,700
Registered Dietitian	I	57	$61,000	$77,250	$93,500
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
RN (PACE)	M	480	$85,000	$109,050	$133,100
Security Analyst Int	M	534	$85,000	$109,050	$133,100
Security Analyst Sr	N	474	$95,000	$120,650	$146,300
Security Officer	B	311	$42,432	$48,716	$55,000
SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
Social Worker	J	463	$65,000	$82,550	$100,100
Social Worker Sr	K	690	$70,000	$88,900	$107,800
* Sr Director	T	896	$182,000	$240,600	$299,200
Sr Manager I	P	897	$117,000	$149,250	$181,500
Sr Manager II	Q	898	$130,000	$166,200	$202,400
Sr Manager III	R	899	$144,000	$184,200	$224,400
Sr Manager IV	S	900	$154,000	$204,600	$255,200
Supervisor Accounting	M	434	$85,000	$109,050	$133,100
Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
Supervisor Case Management	M	86	$85,000	$109,050	$133,100
Supervisor Claims	J	219	$65,000	$82,550	$100,100
Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
Supervisor Encounters	I	253	$61,000	$77,250	$93,500

CalOptima - Annual Base Salary Schedule—

Revised and Approved by CalOptima Board of Directors: June 02, 2022

Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: June 05, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	M	419	$85,000	$109,050	$133,100
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: June 02, 2022
Schedule Effective Date/To Be Implemented: June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$71,850	$84,700
	Accountant Int	I	634	$61,000	$77,250	$93,500
	Accountant Sr	K	68	$70,000	$88,900	$107,800
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	TBD	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Board Services Specialist	E	435	$48,000	$58,100	$68,200
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	H	49	$59,000	$71,850	$84,700
	Buyer Sr	I	67	$61,000	$77,250	$93,500
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300

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CalOptima - Annual Base Salary Schedule
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clincal Trainer	M	TBD	$85,000	$109,050	$133,100
	Clincal Trainer (LVN)	L	TBD	$77,000	$98,450	$119,900
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	K	385	$70,000	$88,900	$107,800
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$43,281	$50,790	$58,300
	Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$41,600	$46,100	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	901	$77,000	$98,450	$119,900

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CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: June 02, 2022
Schedule Effective Date/To Be Implemented: June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	TBD	$85,000	$109,050	$133,100
	Financial Analyst IV	N	TBD	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
	Human Resources Specialist	G	505	$55,000	$66,550	$78,100
	Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
	Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
	Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
	Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
	Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
	Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
	Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
	Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
	Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
	Intern	A	237	$41,600	$46,100	$50,600
	Investigator Sr	I	553	$61,000	$77,250	$93,500
	Kitchen Assistant	A	585	$41,600	$46,100	$50,600
	Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
	Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
	LVN (PACE)	K	533	$70,000	$88,900	$107,800

CalOptima - Annual Base Salary Schedule
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Job Title	Pay Grade	Job Code	Min	Mid	Max
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$41,600	$46,100	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900
Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
Manager PACE Center	N	432	$95,000	$120,650	$146,300
Manager Population Health Management	N	674	$95,000	$120,650	$146,300
Manager Process Excellence	O	622	$105,000	$134,450	$163,900
Manager Program Implementation	N	488	$95,000	$120,650	$146,300
Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
Manager Provider Network	O	191	$105,000	$134,450	$163,900
Manager Provider Relations	M	171	$85,000	$109,050	$133,100
Manager Purchasing	O	275	$105,000	$134,450	$163,900
Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
Manager Strategic Development	O	603	$105,000	$134,450	$163,900
Manager Utilization Management	P	250	$117,000	$149,250	$181,500
Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Medical Assistant	C	535	$43,281	$50,790	$58,300
	Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
	Medical Records Clerk	B	523	$42,432	$48,716	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
	Office Clerk	A	335	$41,600	$46,100	$50,600
	OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
	OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
	OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
	OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
	OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
	Outreach Specialist	C	218	$43,281	$50,790	$58,300
	Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
	Payroll Specialist	E	554	$48,000	$58,100	$68,200
	Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
	Performance Analyst	I	538	$61,000	$77,250	$93,500
	Personal Care Attendant	A	485	$41,600	$46,100	$50,600
	Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
	Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
	Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
	Pharmacy Resident	G	379	$55,000	$66,550	$78,100
	Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
	Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
	Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
	Physical Therapist	L	530	$77,000	$98,450	$119,900
	Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
	Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
	Principal Financial Analyst	O	TBD	$105,000	$134,450	$163,900
	Privacy Manager	N	536	$95,000	$120,650	$146,300
	Privacy Officer	O	648	$105,000	$134,450	$163,900
	Process Excellence Manager	N	529	$95,000	$120,650	$146,300
	Program Assistant	C	24	$43,281	$50,790	$58,300
	Program Coordinator	C	284	$43,281	$50,790	$58,300
	Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
	Program Manager	L	421	$77,000	$98,450	$119,900
	Program Manager Sr	M	594	$85,000	$109,050	$133,100
	Program Specialist	E	36	$48,000	$58,100	$68,200
	Program Specialist Int	G	61	$55,000	$66,550	$78,100
	Program Specialist Sr	I	508	$61,000	$77,250	$93,500
	Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
	Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
	Programmer	K	43	$70,000	$88,900	$107,800
	Programmer Int	M	74	$85,000	$109,050	$133,100
	Programmer Sr	N	80	$95,000	$120,650	$146,300

CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: June 02, 2022
Schedule Effective Date/To Be Implemented: June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Project Manager	L	81	$77,000	$98,450	$119,900
	Project Manager - Lead	M	467	$85,000	$109,050	$133,100
	Project Manager Sr	N	105	$95,000	$120,650	$146,300
	Project Specialist	E	291	$48,000	$58,100	$68,200
	Project Specialist Sr	I	503	$61,000	$77,250	$93,500
	Projects Analyst	G	254	$55,000	$66,550	$78,100
	Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
	Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
	Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
	Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
	Provider Network Specialist	H	44	$59,000	$71,850	$84,700
	Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
	Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
	Provider Relations Rep	G	205	$55,000	$66,550	$78,100
	Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
	Publications Coordinator	G	293	$55,000	$66,550	$78,100
	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$42,432	$48,716	$55,000
	Records Manager	Q	778	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$42,432	$48,716	$55,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
*	Sr Director	T	896	$182,000	$240,600	$299,200
	Sr Manager I	P	897	$117,000	$149,250	$181,500
	Sr Manager II	Q	898	$130,000	$166,200	$202,400
	Sr Manager III	R	899	$144,000	$184,200	$224,400
	Sr Manager IV	S	900	$154,000	$204,600	$255,200
	Supervisor Accounting	M	434	$85,000	$109,050	$133,100
	Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
	Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
	Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
	Supervisor Case Management	M	86	$85,000	$109,050	$133,100
	Supervisor Claims	J	219	$65,000	$82,550	$100,100
	Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
	Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
	Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
	Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
	Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
	Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
	Supervisor Encounters	I	253	$61,000	$77,250	$93,500

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	M	419	$85,000	$109,050	$133,100
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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Policy: GA.8058
Title: **Salary Schedule**
Department: CalOptima Administrative
Section: Human Resources

CEO Approval: */s/*

Effective Date: 05/01/2014
Revised Date: 03/03/2022

Applicable to:
☐ Medi-Cal
☐ OneCare
☐ OneCare Connect
☐ PACE
☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

1 8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 03/03/2022; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **IX. GLOSSARY**
2
3 Not Applicable
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For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources

CEO Approval: /s/

Effective Date:	05/01/2014
Revised Date:	03/03/2022

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 03/03/2022; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

IX. GLOSSARY

Not Applicable

For 20240801 BOD Review Only

~~Attachment A:~~ CalOptima - Annual Base Salary Schedule
~~(~~Revised and Approved by CalOptima Board of Directors: March 03, 2022~~)~~
Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: March 13, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$71,850	$84,700
	Accountant Int	I	634	$61,000	$77,250	$93,500
	Accountant Sr	K	68	$70,000	$88,900	$107,800
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	TBD	$130,000	$166,200	$202,400
	Actuary Sr	P	TBD	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	TBD	$117,000	$149,250	$181,500
	Associate Director II	Q	TBD	$130,000	$166,200	$202,400
	Associate Director III	R	TBD	$144,000	$184,200	$224,400
	Associate Director IV	S	TBD	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Board Services Specialist	E	435	$48,000	$58,100	$68,200
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	H	49	$59,000	$71,850	$84,700
	Buyer Sr	I	67	$61,000	$77,250	$93,500
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	TBD	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	TBD	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	TBD	$313,000	$414,450	$515,900

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~~Attachment A:~~ CalOptima - Annual Base Salary Schedule
~~(~~Revised and Approved by CalOptima Board of Directors: March 03, 2022~~)~~
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	TBD	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$41,000	$49,650	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	TBD	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	TBD	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	K	385	$70,000	$88,900	$107,800
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$41,000	$49,650	$58,300
	Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Entry Tech	A	3	$36,000	$43,300	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	TBD	$77,000	$98,450	$119,900
*	Director I	Q	TBD	$130,000	$166,200	$202,400
*	Director II	R	TBD	$144,000	$184,200	$224,400
*	Director III	S	TBD	$154,000	$204,600	$255,200
*	Director IV	T	TBD	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	TBD	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst	J	51	$65,000	$82,550	$100,100
	Financial Analyst Sr	L	84	$77,000	$98,450	$119,900
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Human Resources Specialist	G	505	$55,000	$66,550	$78,100
Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$36,000	$43,300	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
Kitchen Assistant	A	585	$36,000	$43,300	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$36,000	$43,300	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900
Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
Manager PACE Center	N	432	$95,000	$120,650	$146,300
Manager Population Health Management	N	674	$95,000	$120,650	$146,300
Manager Process Excellence	O	622	$105,000	$134,450	$163,900
Manager Program Implementation	N	488	$95,000	$120,650	$146,300
Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
Manager Provider Network	O	191	$105,000	$134,450	$163,900
Manager Provider Relations	M	171	$85,000	$109,050	$133,100
Manager Purchasing	O	275	$105,000	$134,450	$163,900
Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
Manager Strategic Development	O	603	$105,000	$134,450	$163,900
Manager Utilization Management	P	250	$117,000	$149,250	$181,500
Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
Medical Assistant	C	535	$41,000	$49,650	$58,300
Medical Authorization Asst	C	11	$41,000	$49,650	$58,300
Medical Case Manager	L	72	$77,000	$98,450	$119,900
Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
* Medical Director	V	306	$266,000	$351,900	$437,800
Medical Records & Health Plan Assistant	B	548	$38,000	$46,500	$55,000
Medical Records Clerk	B	523	$38,000	$46,500	$55,000
Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
Occupational Therapist	L	531	$77,000	$98,450	$119,900
Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
Office Clerk	A	335	$36,000	$43,300	$50,600
OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
OneCare Partner - Service	C	231	$41,000	$49,650	$58,300
OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
Outreach Specialist	C	218	$41,000	$49,650	$58,300
Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
Payroll Specialist	E	554	$48,000	$58,100	$68,200

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Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
Performance Analyst	I	538	$61,000	$77,250	$93,500
Personal Care Attendant	A	485	$36,000	$43,300	$50,600
Personal Care Attendant - Lead	B	498	$38,000	$46,500	$55,000
Personal Care Coordinator	C	525	$41,000	$49,650	$58,300
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$41,000	$49,650	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager	N	529	$95,000	$120,650	$146,300
Program Assistant	C	24	$41,000	$49,650	$58,300
Program Coordinator	C	284	$41,000	$49,650	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100
Programmer Sr	N	80	$95,000	$120,650	$146,300
Project Manager	L	81	$77,000	$98,450	$119,900
Project Manager - Lead	M	467	$85,000	$109,050	$133,100
Project Manager Sr	N	105	$95,000	$120,650	$146,300
Project Specialist	E	291	$48,000	$58,100	$68,200
Project Specialist Sr	I	503	$61,000	$77,250	$93,500
Projects Analyst	G	254	$55,000	$66,550	$78,100
Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
Provider Network Specialist	H	44	$59,000	$71,850	$84,700
Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
Provider Relations Rep	G	205	$55,000	$66,550	$78,100
Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
Publications Coordinator	G	293	$55,000	$66,550	$78,100

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	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$38,000	$46,500	$55,000
	Records Manager	Q	TBD	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$38,000	$46,500	$55,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
*	Sr Director	T	TBD	$182,000	$240,600	$299,200
	Sr Manager I	P	TBD	$117,000	$149,250	$181,500
	Sr Manager II	Q	TBD	$130,000	$166,200	$202,400
	Sr Manager III	R	TBD	$144,000	$184,200	$224,400
	Sr Manager IV	S	TBD	$154,000	$204,600	$255,200
	Supervisor Accounting	M	434	$85,000	$109,050	$133,100
	Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
	Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
	Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
	Supervisor Case Management	M	86	$85,000	$109,050	$133,100
	Supervisor Claims	J	219	$65,000	$82,550	$100,100
	Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
	Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
	Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
	Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
	Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
	Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
	Supervisor Encounters	I	253	$61,000	$77,250	$93,500
	Supervisor Facilities	J	162	$65,000	$82,550	$100,100
	Supervisor Finance	M	419	$85,000	$109,050	$133,100
	Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
	Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
	Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
	Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
	Supervisor MSSP	M	348	$85,000	$109,050	$133,100
	Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
	Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500

~~Attachment A:~~ CalOptima - Annual Base Salary Schedule
~~(~~Revised and Approved by CalOptima Board of Directors: March 03, 2022~~)~~
Schedule Effective Date/To ~~b~~Be ~~i~~Implemented: March 13, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$38,000	$46,500	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$71,850	$84,700
	Accountant Int	I	634	$61,000	$77,250	$93,500
	Accountant Sr	K	68	$70,000	$88,900	$107,800
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	TBD	$130,000	$166,200	$202,400
	Actuary Sr	P	TBD	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	TBD	$117,000	$149,250	$181,500
	Associate Director II	Q	TBD	$130,000	$166,200	$202,400
	Associate Director III	R	TBD	$144,000	$184,200	$224,400
	Associate Director IV	S	TBD	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Board Services Specialist	E	435	$48,000	$58,100	$68,200
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	H	49	$59,000	$71,850	$84,700
	Buyer Sr	I	67	$61,000	$77,250	$93,500
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	TBD	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	TBD	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	TBD	$313,000	$414,450	$515,900

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	TBD	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$41,000	$49,650	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	TBD	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	TBD	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	K	385	$70,000	$88,900	$107,800
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$41,000	$49,650	$58,300
	Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Entry Tech	A	3	$36,000	$43,300	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	TBD	$77,000	$98,450	$119,900
*	Director I	Q	TBD	$130,000	$166,200	$202,400
*	Director II	R	TBD	$144,000	$184,200	$224,400
*	Director III	S	TBD	$154,000	$204,600	$255,200
*	Director IV	T	TBD	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	TBD	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst	J	51	$65,000	$82,550	$100,100
	Financial Analyst Sr	L	84	$77,000	$98,450	$119,900
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Human Resources Specialist	G	505	$55,000	$66,550	$78,100
Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$36,000	$43,300	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
Kitchen Assistant	A	585	$36,000	$43,300	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$36,000	$43,300	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
	Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
	Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
	Manager MSSP	O	393	$105,000	$134,450	$163,900
	Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
	Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
	Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
	Manager PACE Center	N	432	$95,000	$120,650	$146,300
	Manager Population Health Management	N	674	$95,000	$120,650	$146,300
	Manager Process Excellence	O	622	$105,000	$134,450	$163,900
	Manager Program Implementation	N	488	$95,000	$120,650	$146,300
	Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
	Manager Provider Network	O	191	$105,000	$134,450	$163,900
	Manager Provider Relations	M	171	$85,000	$109,050	$133,100
	Manager Purchasing	O	275	$105,000	$134,450	$163,900
	Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
	Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
	Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
	Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
	Manager Strategic Development	O	603	$105,000	$134,450	$163,900
	Manager Utilization Management	P	250	$117,000	$149,250	$181,500
	Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
	Medical Assistant	C	535	$41,000	$49,650	$58,300
	Medical Authorization Asst	C	11	$41,000	$49,650	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$38,000	$46,500	$55,000
	Medical Records Clerk	B	523	$38,000	$46,500	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
	Office Clerk	A	335	$36,000	$43,300	$50,600
	OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
	OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
	OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
	OneCare Partner - Service	C	231	$41,000	$49,650	$58,300
	OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
	Outreach Specialist	C	218	$41,000	$49,650	$58,300
	Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
	Payroll Specialist	E	554	$48,000	$58,100	$68,200

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Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
Performance Analyst	I	538	$61,000	$77,250	$93,500
Personal Care Attendant	A	485	$36,000	$43,300	$50,600
Personal Care Attendant - Lead	B	498	$38,000	$46,500	$55,000
Personal Care Coordinator	C	525	$41,000	$49,650	$58,300
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$41,000	$49,650	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager	N	529	$95,000	$120,650	$146,300
Program Assistant	C	24	$41,000	$49,650	$58,300
Program Coordinator	C	284	$41,000	$49,650	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100
Programmer Sr	N	80	$95,000	$120,650	$146,300
Project Manager	L	81	$77,000	$98,450	$119,900
Project Manager - Lead	M	467	$85,000	$109,050	$133,100
Project Manager Sr	N	105	$95,000	$120,650	$146,300
Project Specialist	E	291	$48,000	$58,100	$68,200
Project Specialist Sr	I	503	$61,000	$77,250	$93,500
Projects Analyst	G	254	$55,000	$66,550	$78,100
Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
Provider Network Specialist	H	44	$59,000	$71,850	$84,700
Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
Provider Relations Rep	G	205	$55,000	$66,550	$78,100
Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
Publications Coordinator	G	293	$55,000	$66,550	$78,100

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CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: March 03, 2022
Schedule Effective Date/To Be Implemented: March 13, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$38,000	$46,500	$55,000
	Records Manager	Q	TBD	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$38,000	$46,500	$55,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
*	Sr Director	T	TBD	$182,000	$240,600	$299,200
	Sr Manager I	P	TBD	$117,000	$149,250	$181,500
	Sr Manager II	Q	TBD	$130,000	$166,200	$202,400
	Sr Manager III	R	TBD	$144,000	$184,200	$224,400
	Sr Manager IV	S	TBD	$154,000	$204,600	$255,200
	Supervisor Accounting	M	434	$85,000	$109,050	$133,100
	Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
	Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
	Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
	Supervisor Case Management	M	86	$85,000	$109,050	$133,100
	Supervisor Claims	J	219	$65,000	$82,550	$100,100
	Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
	Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
	Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
	Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
	Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
	Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
	Supervisor Encounters	I	253	$61,000	$77,250	$93,500
	Supervisor Facilities	J	162	$65,000	$82,550	$100,100
	Supervisor Finance	M	419	$85,000	$109,050	$133,100
	Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
	Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
	Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
	Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
	Supervisor MSSP	M	348	$85,000	$109,050	$133,100
	Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
	Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500

Back to Agenda Back to Item

CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: March 03, 2022
Schedule Effective Date/To Be Implemented: March 13, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$38,000	$46,500	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	09/02/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

1 8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: as of 09/02/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **GLOSSARY**
2
3 Not Applicable
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For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	09/02/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
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13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 09/02/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: September 2, 2021
Schedule Effective Date/To bBe Implemented: September 12, 2021
~~Effective as of May 01, 2014~~

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$368,000	$460,000	$552,000
**	Chief Executive Officer	Z	138	$560,000	$625,000	$765,000
**	Chief Financial Officer	X	134	$368,000	$460,000	$552,000
**	Chief Information Officer	W	131	$313,000	$391,000	$469,000
**	Chief of Staff	U	TBD	$226,000	$282,000	$338,000
**	Chief Medical Officer	X	137	$368,000	$460,000	$552,000

CalOptima - Annual Base Salary Schedule—

Revised and Approved by CalOptima Board of Directors: September 2, 2021

Schedule Effective Date/To ~~b~~Be Implemented: September 12, 2021

~~Effective as of May 01, 2014~~

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Operating Officer	Y	136	$433,000	$540,909	$649,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$313,000	$391,000	$469,000
**	Deputy Chief Medical Officer	W	561	$313,000	$391,000	$469,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$226,000	$282,000	$338,000
**	Executive Director Clinical Operations	U	501	$226,000	$282,000	$338,000
**	Executive Director Compliance	U	493	$226,000	$282,000	$338,000
**	Executive Director Finance	U	TBD	$226,000	$282,000	$338,000
**	Executive Director Human Resources	U	494	$226,000	$282,000	$338,000
**	Executive Director Network Operations	U	632	$226,000	$282,000	$338,000
**	Executive Director Operations	U	276	$226,000	$282,000	$338,000
**	Executive Director Program Implementation	U	490	$226,000	$282,000	$338,000
**	Executive Director Public Affairs	U	290	$226,000	$282,000	$338,000
**	Executive Director Quality & Population Health Management	U	676	$226,000	$282,000	$338,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Investigator Sr	I	553	$61,000	$73,000	$85,000
IS Coordinator	E	365	$48,000	$55,000	$62,000
IS Project Manager	N	424	$95,000	$114,000	$133,000
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
IS Project Specialist	K	549	$70,000	$84,000	$98,000
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
	Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
	Manager PACE Center	N	432	$95,000	$114,000	$133,000
	Manager Population Health Management	N	674	$95,000	$114,000	$133,000
	Manager Process Excellence	O	622	$105,000	$127,000	$149,000
	Manager Program Implementation	N	488	$95,000	$114,000	$133,000
	Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
	Manager Provider Network	O	191	$105,000	$127,000	$149,000
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$266,000	$332,000	$398,000
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
Pharmacy Resident	G	379	$55,000	$63,000	$71,000
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
Physical Therapist	L	530	$77,000	$93,000	$109,000
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
Privacy Manager	N	536	$95,000	$114,000	$133,000
Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
	Receptionist	B	140	$38,000	$44,000	$50,000
	Records Manager	Q	TBD	$130,000	$157,000	$184,000
	Recreational Therapist	H	487	$59,000	$68,000	$77,000
	Registered Dietitian	I	57	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
	RN (PACE)	M	480	$85,000	$103,000	$121,000
	Security Analyst Int	M	534	$85,000	$103,000	$121,000
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000
	Security Officer	B	311	$38,000	$44,000	$50,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 09/02/2021

CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: September 2, 2021
Schedule Effective Date/To Be Implemented: September 12, 2021

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$368,000	$460,000	$552,000
**	Chief Executive Officer	Z	138	$560,000	$625,000	$765,000
**	Chief Financial Officer	X	134	$368,000	$460,000	$552,000
**	Chief Information Officer	W	131	$313,000	$391,000	$469,000
**	Chief of Staff	U	TBD	$226,000	$282,000	$338,000
**	Chief Medical Officer	X	137	$368,000	$460,000	$552,000
**	Chief Operating Officer	Y	136	$433,000	$540,909	$649,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$313,000	$391,000	$469,000
**	Deputy Chief Medical Officer	W	561	$313,000	$391,000	$469,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$226,000	$282,000	$338,000
**	Executive Director Clinical Operations	U	501	$226,000	$282,000	$338,000
**	Executive Director Compliance	U	493	$226,000	$282,000	$338,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Executive Director Finance	U	TBD	$226,000	$282,000	$338,000
**	Executive Director Human Resources	U	494	$226,000	$282,000	$338,000
**	Executive Director Network Operations	U	632	$226,000	$282,000	$338,000
**	Executive Director Operations	U	276	$226,000	$282,000	$338,000
**	Executive Director Program Implementation	U	490	$226,000	$282,000	$338,000
**	Executive Director Public Affairs	U	290	$226,000	$282,000	$338,000
**	Executive Director Quality & Population Health Management	U	676	$226,000	$282,000	$338,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$266,000	$332,000	$398,000
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000

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CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: September 2, 2021
Schedule Effective Date/To Be Implemented: September 12, 2021

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 09/02/2021

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Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	08/05/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima – Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: as of 08/05/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	08/05/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima – Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 08/05/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

1
2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative

1

For 20240801 BOD Review Only

1 **GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: August 05, 2021
Schedule Effective Date/To bBe Implemented: August 05, 2021
~~Effective as of May 01, 2014~~

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$289,000	$361,000	$433,000
**	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
**	Chief Financial Officer	X	134	$289,000	$361,000	$433,000
**	Chief Information Officer	W	131	$246,000	$307,000	$368,000
**	Chief of Staff	U	TBD	$209,000	$261,000	$313,000
**	Chief Medical Officer	X	137	$289,000	$361,000	$433,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Operating Officer	X	136	$289,000	$361,000	$433,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000

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CalOptima - Annual Base Salary Schedule—
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000

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CalOptima - Annual Base Salary Schedule~~—~~
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Schedule Effective Date/To ~~b~~Be Implemented: August 05, 2021
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Job Title	Pay Grade	Job Code	Min	Mid	Max
Executive Assistant	G	339	$55,000	$63,000	$71,000
Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
** Executive Director Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
** Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
** Executive Director Compliance	U	493	$209,000	$261,000	$313,000
** Executive Director Human Resources	U	494	$209,000	$261,000	$313,000
** Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
** Executive Director Operations	U	276	$209,000	$261,000	$313,000
** Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
** Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000
** Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
Facilities Coordinator	E	438	$48,000	$55,000	$62,000
Financial Analyst	J	51	$65,000	$78,000	$91,000
Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
Graphic Designer	K	387	$70,000	$84,000	$98,000
Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
Health Coach	K	556	$70,000	$84,000	$98,000
Health Educator	H	47	$59,000	$68,000	$77,000
Health Educator Sr	I	355	$61,000	$73,000	$85,000
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
Help Desk Technician	E	571	$48,000	$55,000	$62,000
Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
HR Assistant	D	181	$44,000	$51,000	$58,000
HR Business Partner	M	584	$85,000	$103,000	$121,000
HR Coordinator	F	316	$51,000	$59,000	$67,000
HR Representative	J	278	$65,000	$78,000	$91,000
HR Representative Sr	L	350	$77,000	$93,000	$109,000
HR Specialist	G	505	$55,000	$63,000	$71,000
HR Specialist Sr	H	608	$59,000	$68,000	$77,000
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
Intern	A	237	$36,000	$41,000	$46,000
Investigator Sr	I	553	$61,000	$73,000	$85,000

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CalOptima - Annual Base Salary Schedule—
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Job Title	Pay Grade	Job Code	Min	Mid	Max
IS Coordinator	E	365	$48,000	$55,000	$62,000
IS Project Manager	N	424	$95,000	$114,000	$133,000
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
IS Project Specialist	K	549	$70,000	$84,000	$98,000
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000

Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000
Manager Provider Relations	M	171	$85,000	$103,000	$121,000
Manager Purchasing	O	275	$105,000	$127,000	$149,000
Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
Manager Strategic Development	O	603	$105,000	$127,000	$149,000
Manager Utilization Management	P	250	$117,000	$141,000	$165,000
Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
Medical Assistant	C	535	$41,000	$47,000	$53,000
Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
Medical Case Manager	L	72	$77,000	$93,000	$109,000
Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
* Medical Director	V	306	$221,400	$276,300	$331,200
Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
Medical Records Clerk	B	523	$38,000	$44,000	$50,000
Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
Occupational Therapist	L	531	$77,000	$93,000	$109,000
Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
Office Clerk	A	335	$36,000	$41,000	$46,000
OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
Outreach Specialist	C	218	$41,000	$47,000	$53,000
Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
Payroll Specialist	E	554	$48,000	$55,000	$62,000
Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
Performance Analyst	I	538	$61,000	$73,000	$85,000
Personal Care Attendant	A	485	$36,000	$41,000	$46,000
Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
Personal Care Coordinator	C	525	$41,000	$47,000	$53,000

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Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
Pharmacy Resident	G	379	$55,000	$63,000	$71,000
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
Physical Therapist	L	530	$77,000	$93,000	$109,000
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
Privacy Manager	N	536	$95,000	$114,000	$133,000
Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Receptionist	B	140	$38,000	$44,000	$50,000
	Records Manager	Q	TBD	$130,000	$157,000	$184,000
	Recreational Therapist	H	487	$59,000	$68,000	$77,000
	Registered Dietitian	I	57	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
	RN (PACE)	M	480	$85,000	$103,000	$121,000
	Security Analyst Int	M	534	$85,000	$103,000	$121,000
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000
	Security Officer	B	311	$38,000	$44,000	$50,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000

CalOptima - Annual Base Salary Schedule—

Revised and Approved by CalOptima Board of Directors: August 05, 2021

Schedule Effective Date/To bBe Implemented: August 05, 2021

~~**Effective as of May 01, 2014**~~

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 08/05/2021

CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: August 05, 2021
Schedule Effective Date/To Be Implemented: August 05, 2021

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$289,000	$361,000	$433,000
**	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
**	Chief Financial Officer	X	134	$289,000	$361,000	$433,000
**	Chief Information Officer	W	131	$246,000	$307,000	$368,000
**	Chief of Staff	U	TBD	$209,000	$261,000	$313,000
**	Chief Medical Officer	X	137	$289,000	$361,000	$433,000
**	Chief Operating Officer	X	136	$289,000	$361,000	$433,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Claims Examiner	C	9	$41,000	$47,000	$53,000
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
Claims QA Analyst	E	28	$48,000	$55,000	$62,000
Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
Clerk of the Board	O	59	$105,000	$127,000	$149,000
Clinical Auditor	L	567	$77,000	$93,000	$109,000
Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
Communications Specialist	G	188	$55,000	$63,000	$71,000
Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
Community Partner	G	575	$55,000	$63,000	$71,000
Community Partner Sr	H	612	$59,000	$68,000	$77,000
Community Relations Specialist	G	288	$55,000	$63,000	$71,000
Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
Contract Administrator	K	385	$70,000	$84,000	$98,000
Contracts Manager	M	207	$85,000	$103,000	$121,000
Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
Contracts Specialist	I	257	$61,000	$73,000	$85,000
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
* Controller	T	464	$182,000	$227,000	$272,000
Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
Customer Service Rep	C	5	$41,000	$47,000	$53,000
Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
Data Analyst	J	337	$65,000	$78,000	$91,000
Data Analyst Int	K	341	$70,000	$84,000	$98,000
Data Analyst Sr	L	342	$77,000	$93,000	$109,000
Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
Data Entry Tech	A	3	$36,000	$41,000	$46,000
Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
Database Administrator	L	90	$77,000	$93,000	$109,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
**	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
**	Executive Director Compliance	U	493	$209,000	$261,000	$313,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000
**	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
**	Executive Director Operations	U	276	$209,000	$261,000	$313,000
**	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
**	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000
**	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000
	Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000
Manager Provider Relations	M	171	$85,000	$103,000	$121,000
Manager Purchasing	O	275	$105,000	$127,000	$149,000

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$221,400	$276,300	$331,200
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000
	Privacy Officer	O	648	$105,000	$127,000	$149,000
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000
SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
Social Worker	J	463	$65,000	$78,000	$91,000

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CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: August 05, 2021
Schedule Effective Date/To Be Implemented: August 05, 2021

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
	Technical Analyst Int	J	64	$65,000	$78,000	$91,000
	Technical Analyst Sr	L	75	$77,000	$93,000	$109,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 08/05/2021

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	03/04/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
10
11 **II. POLICY**
12
13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
17
18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima – Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: ~~as of~~ 03/04/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **GLOSSARY**
2
3 Not Applicable
4

For 20240801 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	05/01/2014
Revised Date:	03/04/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20240801 BOD Review Only

1 **I. PURPOSE**
2
3 A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including
4 job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).
5
6 B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2,
7 California Code of Regulations (CCR) §570.5 so that employees who are members of the California
8 Public Employees Retirement System (CalPERS) have their compensation considered qualified for
9 pension calculation under CalPERS regulations.
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11 **II. POLICY**
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13 A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5,
14 CalOptima has established the attached salary schedule for each CalOptima job position. In order
15 for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department
16 (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:
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18 1. Approval and adoption by the governing body in accordance with requirements applicable to
19 public meetings laws;
20
21 2. Identification of position titles for every employee position;
22
23 3. Listing of pay rate for each identified position, which may be stated as a single amount or as
24 multiple amounts with a range;
25
26 4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily,
27 bi-weekly, monthly, bi-monthly, or annually;
28
29 5. Posted at the employer's office or immediately accessible and available for public review
30 from the employer during normal business hours or posted on the employer's internet
31 website;
32
33 6. Indicates the effective date and date of any revisions;
34
35 7. Retained by the employer and available for public inspection for not less than five (5) years;
36 and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised and Approved by CalOptima Board of Directors: 03/04/2021; Amended 08/01/2024)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors

For 20240801 BOD Review Only

Date	Meeting
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/01/2024	Regular Meeting of the CalOptima Health Board of Directors

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2 **VIII. REVISION HISTORY**
3

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative

For 20240801 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative

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For 20240801 BOD Review Only

1 **GLOSSARY**
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3 Not Applicable
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For 20240801 BOD Review Only

CalOptima - Annual Base Salary Schedule—

Revised and Approved by CalOptima Board of Directors: March 04, 2021

Schedule Effective Date/To ~~b~~Be Implemented March 14, 2021

~~Effective as of May 01, 2014~~

Job Title	Pay Grade	Job Code	Min	Mid	Max
Accountant	H	39	$59,000	$68,000	$77,000
Accountant Int	I	634	$61,000	$73,000	$85,000
Accountant Sr	K	68	$70,000	$84,000	$98,000
Accounting Clerk	D	334	$44,000	$51,000	$58,000
Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
Actuarial Analyst	I	558	$61,000	$73,000	$85,000
Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
Actuary	O	357	$105,000	$127,000	$149,000
Administrative Assistant	D	19	$44,000	$51,000	$58,000
Analyst	H	562	$59,000	$68,000	$77,000
Analyst Int	I	563	$61,000	$73,000	$85,000
Analyst Sr	J	564	$65,000	$78,000	$91,000
Applications Analyst	I	232	$61,000	$73,000	$85,000
Applications Analyst Int	J	233	$65,000	$78,000	$91,000
Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
Associate Director	P	682	$117,000	$141,000	$165,000
Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
Auditor	I	565	$61,000	$73,000	$85,000
Auditor Sr	J	566	$65,000	$78,000	$91,000
Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
Biostatistics Manager	M	418	$85,000	$103,000	$121,000
Board Services Specialist	E	435	$48,000	$55,000	$62,000
Business Analyst	J	40	$65,000	$78,000	$91,000
Business Analyst Sr	L	611	$77,000	$93,000	$109,000
Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
Buyer	G	29	$55,000	$63,000	$71,000
Buyer Int	H	49	$59,000	$68,000	$77,000
Buyer Sr	I	67	$61,000	$73,000	$85,000
Care Manager	K	657	$70,000	$84,000	$98,000
Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
Certified Coder	H	399	$59,000	$68,000	$77,000
Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
Change Control Administrator	I	499	$61,000	$73,000	$85,000
Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
** Chief Counsel	X	132	$289,000	$361,000	$433,000
** Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
** Chief Financial Officer	X	134	$289,000	$361,000	$433,000
** Chief Information Officer	W	131	$246,000	$307,000	$368,000
** Chief Medical Officer	X	137	$289,000	$361,000	$433,000
** Chief Operating Officer	X	136	$289,000	$361,000	$433,000

CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: March 04, 2021
Schedule Effective Date/To bBe Implemented March 14, 2021
~~**Effective as of May 01, 2014**~~

Job Title	Pay Grade	Job Code	Min	Mid	Max
Claims - Lead	G	574	$55,000	$63,000	$71,000
Claims Examiner	C	9	$41,000	$47,000	$53,000
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
Claims QA Analyst	E	28	$48,000	$55,000	$62,000
Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
Clerk of the Board	O	59	$105,000	$127,000	$149,000
Clinical Auditor	L	567	$77,000	$93,000	$109,000
Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
Communications Specialist	G	188	$55,000	$63,000	$71,000
Community Partner	G	575	$55,000	$63,000	$71,000
Community Partner Sr	H	612	$59,000	$68,000	$77,000
Community Relations Specialist	G	288	$55,000	$63,000	$71,000
Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
Contract Administrator	K	385	$70,000	$84,000	$98,000
Contracts Manager	M	207	$85,000	$103,000	$121,000
Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
Contracts Specialist	I	257	$61,000	$73,000	$85,000
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
* Controller	T	464	$182,000	$227,000	$272,000
Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
Customer Service Rep	C	5	$41,000	$47,000	$53,000
Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
Data Analyst	J	337	$65,000	$78,000	$91,000
Data Analyst Int	K	341	$70,000	$84,000	$98,000
Data Analyst Sr	L	342	$77,000	$93,000	$109,000
Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
Data Entry Tech	A	3	$36,000	$41,000	$46,000
Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
Database Administrator	L	90	$77,000	$93,000	$109,000

CalOptima - Annual Base Salary Schedule—

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Schedule Effective Date/To ~~b~~Be Implemented March 14, 2021

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	Q	675	$130,000	$157,000	$184,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Provider Data Quality	Q	655	$130,000	$157,000	$184,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
**	Executive Director Compliance	U	493	$209,000	$261,000	$313,000
**	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000

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CalOptima - Annual Base Salary Schedule—
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Schedule Effective Date/To bBe Implemented March 14, 2021
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
**	Executive Director Operations	U	276	$209,000	$261,000	$313,000
**	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
**	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000
**	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
**	Executive Director, Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000

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CalOptima - Annual Base Salary Schedule—
Revised and Approved by CalOptima Board of Directors: March 04, 2021
Schedule Effective Date/To bBe Implemented March 14, 2021
~~Effective as of May 01, 2014~~

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$221,400	$276,300	$331,200
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000

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CalOptima - Annual Base Salary Schedule—

Revised and Approved by CalOptima Board of Directors: March 04, 2021

Schedule Effective Date/To ~~b~~Be Implemented March 14, 2021

~~Effective as of May 01, 2014~~

Job Title	Pay Grade	Job Code	Min	Mid	Max
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
Privacy Manager	N	536	$95,000	$114,000	$133,000
Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Enrollment Data Coordinator	D	12	$44,000	$51,000	$58,000
Provider Enrollment Data Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	RN (PACE)	M	480	$85,000	$103,000	$121,000
	Security Analyst Int	M	534	$85,000	$103,000	$121,000
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000
	Security Officer	B	311	$38,000	$44,000	$50,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Technical Writer	H	247	$59,000	$68,000	$77,000
Technical Writer Sr	J	470	$65,000	$78,000	$91,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA.8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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CalOptima - Annual Base Salary Schedule
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$289,000	$361,000	$433,000
**	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
**	Chief Financial Officer	X	134	$289,000	$361,000	$433,000
**	Chief Information Officer	W	131	$246,000	$307,000	$368,000
**	Chief Medical Officer	X	137	$289,000	$361,000	$433,000
**	Chief Operating Officer	X	136	$289,000	$361,000	$433,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000
	Claims Examiner	C	9	$41,000	$47,000	$53,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000

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	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	Q	675	$130,000	$157,000	$184,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Provider Data Quality	Q	655	$130,000	$157,000	$184,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
**	Executive Director Compliance	U	493	$209,000	$261,000	$313,000
**	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000
**	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
**	Executive Director Operations	U	276	$209,000	$261,000	$313,000
**	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
**	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000

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**	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
**	Executive Director, Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000
	Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
	Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
	LVN (PACE)	K	533	$70,000	$84,000	$98,000
	LVN Specialist	K	686	$70,000	$84,000	$98,000
	Mailroom Clerk	A	1	$36,000	$41,000	$46,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000
Manager Provider Relations	M	171	$85,000	$103,000	$121,000
Manager Purchasing	O	275	$105,000	$127,000	$149,000
Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000

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CalOptima - Annual Base Salary Schedule
Revised and Approved by CalOptima Board of Directors: March 04, 2021
Schedule Effective Date/To Be Implemented March 14, 2021

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$221,400	$276,300	$331,200
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000
	Privacy Officer	O	648	$105,000	$127,000	$149,000
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000
	Program Assistant	C	24	$41,000	$47,000	$53,000
	Program Coordinator	C	284	$41,000	$47,000	$53,000
	Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
	Program Manager	L	421	$77,000	$93,000	$109,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Program Manager Sr	M	594	$85,000	$103,000	$121,000
	Program Specialist	E	36	$48,000	$55,000	$62,000
	Program Specialist Int	G	61	$55,000	$63,000	$71,000
	Program Specialist Sr	I	508	$61,000	$73,000	$85,000
	Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
	Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
	Programmer	K	43	$70,000	$84,000	$98,000
	Programmer Int	M	74	$85,000	$103,000	$121,000
	Programmer Sr	N	80	$95,000	$114,000	$133,000
	Project Manager	L	81	$77,000	$93,000	$109,000
	Project Manager - Lead	M	467	$85,000	$103,000	$121,000
	Project Manager Sr	N	105	$95,000	$114,000	$133,000
	Project Specialist	E	291	$48,000	$55,000	$62,000
	Project Specialist Sr	I	503	$61,000	$73,000	$85,000
	Projects Analyst	G	254	$55,000	$63,000	$71,000
	Provider Enrollment Data Coordinator	D	12	$44,000	$51,000	$58,000
	Provider Enrollment Data Coordinator Sr	F	586	$51,000	$59,000	$67,000
	Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
	Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
	Provider Network Specialist	H	44	$59,000	$68,000	$77,000
	Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
	Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
	Provider Relations Rep	G	205	$55,000	$63,000	$71,000
	Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
	Publications Coordinator	G	293	$55,000	$63,000	$71,000
	QA Analyst	I	486	$61,000	$73,000	$85,000
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000
	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
	Receptionist	B	140	$38,000	$44,000	$50,000
	Records Manager	Q	TBD	$130,000	$157,000	$184,000
	Recreational Therapist	H	487	$59,000	$68,000	$77,000
	Registered Dietitian	I	57	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000
	RN (PACE)	M	480	$85,000	$103,000	$121,000
	Security Analyst Int	M	534	$85,000	$103,000	$121,000
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000
	Security Officer	B	311	$38,000	$44,000	$50,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
Staff Attorney	P	195	$117,000	$141,000	$165,000
Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
Supervisor Accounting	M	434	$85,000	$103,000	$121,000
Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
Supervisor Case Management	M	86	$85,000	$103,000	$121,000
Supervisor Claims	I	219	$61,000	$73,000	$85,000
Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
Supervisor Encounters	I	253	$61,000	$73,000	$85,000
Supervisor Facilities	J	162	$65,000	$78,000	$91,000
Supervisor Finance	M	419	$85,000	$103,000	$121,000
Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
Supervisor Information Services	N	457	$95,000	$114,000	$133,000
Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
Supervisor MSSP	M	348	$85,000	$103,000	$121,000
Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
Supervisor Payroll	M	517	$85,000	$103,000	$121,000
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Technical Writer	H	247	$59,000	$68,000	$77,000
Technical Writer Sr	J	470	$65,000	$78,000	$91,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

13. Adopt Resolution No. 24-0801-02 Approving and Adopting Volunteers Aged 18 and Older as Employees for the Sole Purpose of Receiving Workers' Compensation Benefits

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

1. Adopt Resolution No. 24-0801-02 approving workers' compensation coverage for volunteers aged 18 and over.

Background

California Labor Code Section 3700 requires employers to provide workers' compensation benefits to their employees. Volunteers are not regarded as employees and therefore are not typically covered by workers' compensation if they become injured or ill while working in the capacity of a volunteer.

Labor Code Section 3363.5 allows public agencies to choose to provide workers' compensation benefits to volunteers by adopting a resolution by its board of directors deeming volunteers as employees of the public agency for the purpose of receiving workers' compensation benefits. With this declaration, volunteers may receive workers' compensation benefits for injuries sustained while engaged in the performance of services under the direction and control of the CalOptima Health Board of Directors.

Discussion

CalOptima Health intends to accept assistance from volunteers for various services in support of CalOptima Health and its members, including assistance with community events and providing opportunities for internships.

Extending workers' compensation protection to volunteers aged 18 and over will serve as a mutual benefit to volunteers as well as CalOptima Health. If a volunteer is deemed to be eligible for workers' compensation coverage, it becomes the injured volunteers' exclusive remedy, and they are precluded from suing the agency for injuries incurred while volunteering. Under workers' compensation, injuries are subject to a schedule of benefits, which can help to control the overall claim costs. The volunteer will have immediate access to the medical treatment needed to cure and relieve the effects of the injury, without the need to sue the agency.

To effectuate this designation, Labor Code Section 3363.5 requires the Board of Directors to adopt a resolution declaring its intent to deem volunteers' employees for workers' compensation coverage. As set forth in the attached resolution, this declaration of volunteers as employees is solely for the purpose of providing workers' compensation benefits to volunteers pursuant to Labor Code Section 3363.5 and does not deem volunteers to be CalOptima Health employees for any other purpose.

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Fiscal Impact

The recommended action has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

Workers' compensation benefits are statutorily and legislatively determined, and as such there are specific monetary and time sensitive limits to these benefits. In contrast, if a volunteer is not extended workers' compensation coverage and becomes injured or ill while performing volunteer services on behalf of CalOptima Health, their only remedy is to file a general liability claim or lawsuit and pursue damages through the civil court system for an undetermined amount of benefits or payments. This can result in leaving the volunteer to cover the medical and financial burden of their injury, costly and time-consuming litigation, and unnecessary delays in obtaining medical treatment.

Volunteers are an asset to CalOptima Health, and staff recommends that CalOptima Health ensure its volunteers are adequately protected by providing workers' compensation benefits in the event they become injured or ill while providing a service and benefit to CalOptima Health.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 24-0801-02 Deeming Volunteers as Employees for the Sole Purpose of Receiving Workers' Compensation Benefits

/s/ Michael Hunn *07/25/2024*

Authorized Signature **Date**

RESOLUTION NO. 24-0801-02

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

Deeming Volunteers as Employees for the Sole Purpose of Receiving Workers' Compensation Benefits

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

WHEREAS, the California Constitution and the Labor Code mandate that employers provide for workers' compensation benefits to employees;

WHEREAS, persons who perform voluntary services and receive no remuneration other than meals, transportation, lodging, or reimbursement for incidental expenses, ("**Volunteers**") are not entitled to receive workers' compensation benefits;

WHEREAS, Labor Code Section 3363.5 allows public agencies to choose to provide workers' compensation benefits to Volunteers by deeming Volunteers as employees of the public agency for the purpose of receiving workers' compensation benefits; and

WHEREAS, pursuant to Labor Code Section 3363.5, CalOptima desires that Volunteers be deemed employees solely for the purpose of receiving workers' compensation benefits under Division 4 of the Labor Code (Section 3200 *et seq.*).

NOW, THEREFORE, BE IT RESOLVED:

I. That, as of the adoption date of this Resolution, the Board of Directors declares that Volunteers be deemed employees of CalOptima only as necessary for those Volunteers to be eligible for workers' compensation benefits under Division 4 of the Labor Code (Section 3200 *et seq.*) and for no other purpose.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 1st day of August, 2024.

AYES: ____________________________

NOES: ____________________________

ABSENT: __________________________

ABSTAIN: _________________________

/s/___________________________________
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

14. Approve Reappointments and Appointments to the Member Advisory and Provider Advisory Committees and Extend the Term for Two Seats on the Member Advisory Committee

Contacts

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

Recommended Actions

1. Reappoint the following individuals to the Member Advisor Committee to each serve a three-year term ending June 30, 2027:
   a. Lee Lombardo as the Children Representative; and
   b. Christine Tolbert as the Persons with Special Needs Representative.

2. Appoint the following individuals to the Member Advisory Committee:
   a. Kim Goll as the Family Support Representative to fulfill an existing term ending June 30, 2026; and
   b. Junie Lazo-Pearson, Ph.D., as the Behavioral/Mental Health Representative for a three-year term ending June 30, 2027.

3. Extend the term for the following two seats on the Member Advisory Committee by one year to June 30, 2025, to create staggered terms on the committee:
   a. Member Advocate Representative; and
   b. Foster Children Representative.

4. Reappoint the following individuals to the Provider Advisory Committee to each serve a three-year term ending June 30, 2027:
   a. Gio Corzo as the Allied Health Representative; and
   b. Jacob Sweidan, M.D., as the Health Network Representative.

5. Appoint the following individuals to the Provider Advisory Committee:
   a. Lorry Leigh Belhumeur, Ph.D., as the Behavioral/Mental Health Representative for a three-year term ending June 30, 2027;
   b. Tiffany Chou, FNP as the Nurse Representative for a three-year term ending June 30, 2027; and
   c. Morgan Mandigo, M.D. as a Physician Representative to fulfill a remaining term through June 30, 2025.

Background

The CalOptima Health Board of Directors (Board) established the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of seventeen voting members and the PAC is comprised of fifteen voting members. Pursuant to the resolution, MAC and PAC members serve three-year terms, except for one

standing seat for the representative from the County of Orange Social Services Agency for MAC and a standing seat for the Orange County Health Care Agency for PAC. The Board is responsible for the appointment of all MAC and PAC members.

Discussion
CalOptima Health staff conducted comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies and CBOs serving the various open positions on both MAC and PAC, and posting recruitment materials on the CalOptima Health website and social media sites.

The MAC Nominations Ad Hoc Subcommittee, composed of committee members Meredith Chillemi, Sara Lee, and Nicole Mastin, evaluated each applicant for the impending openings and forwarded the proposed slate of candidates for the four vacancies to the MAC.

The Board in 2022 changed the term on each seat from two years to three years. Adding a year to the term of the Foster Children's Representative and the Member Advocate Representative aligns the committee with necessary staggered terms.

The PAC Nominations Ad Hoc Subcommittee, composed of PAC Chair Jena Jensen and committee members Andrew Inglis, M.D., and John Nishimoto, O.D., evaluated each applicant and forwarded their recommendations to the PAC for the five vacancies on the PAC.

At the June 13, 2024, joint meeting, MAC and PAC individually approved the recommended slate of candidates as proposed by the MAC and PAC Nominations Ad Hoc Subcommittees and requested that the proposed slate of candidates for each committee be forwarded to the Board for its consideration at the August 1, 2024, meeting. Staff will continue recruitment of the open OneCare Member or Authorized Family Members until these seats are filled on the MAC.

The recommended MAC candidates for the open positions are as follows:

Behavioral/Mental Health Representative
Junie Lazo-Pearson, Ph.D.
Dr. Lazo-Pearson is the Executive Advisor to Advanced Behavioral Health, Inc., a CalOptima contracted behavioral health group. She also serves part-time as an adjunct professor for the Chicago School of Professional Psychology, Irvine Campus, in Irvine, CA. Dr. Lazo-Pearson holds a Ph.D. in Developmental and Child Psychology and is a Board-Certified Behavior Analyst through the Behavior Analyst Certification Board. Dr. Lazo-Pearson has served on the PAC since 2018 and she currently serves as the PAC Vice Chair. She is terming out of her PAC seat and would like to continue assisting CalOptima Health members as part of the MAC.

Children Representative
Lee Lombardo
Lee Lombardo is a licensed clinical social worker and is currently working as a contractor with Children's Cause Orange County and Children and Families Coalition of Orange County helping lead children's mental health projects. Her past experience was as associate executive director of YMCA

community services at the YMCA of Orange County. Ms. Lombardo has worked in the mental health field with children, teens, families and adults, including those with co-occurring mental health and developmental disabilities. She also works with Orange County and state agencies on the Developmental Screening Cohort through Help Me Grow OC, the Orange County Child Care and Development Planning Council and its Inclusion Subcommittee, and the Be Well OC Prevent and Act Early Workgroup.

Family Support Representative
Kim Goll
Kim Goll is the President/Chief Executive Officer of First 5 Orange County. As the Chief Executive Officer of First 5 Orange County, Ms. Goll has firsthand experience working with CalOptima Health families. This includes identifying gaps in the care system, conducting outreach to better understand the gaps and the barriers to services, and identifying opportunities for improvement, funding, and monitoring impacts. These efforts encompass supporting pregnant families, striving to increase compliance with developmental and well-child visits, enhancing access to developmental interventions, and expanding access to new CalAIM benefits.

Persons with Special Needs Representative
Christine Tolbert
Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for thousands of people dealing with an expansive number of medical and/or special needs conditions. She has helped transition people from the state hospital into the community, helping them access health care services through managed care. Ms. Tolbert currently holds the Persons with Special Needs seat and is the current MAC Chair.

The recommended PAC candidates for open seats are as follows:

Allied Health Services Representative
Gio Corzo
Gio Corzo is the Vice President of Home & Care Services for Meals on Wheels. He has more than 20 years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including community-based adult services (CBAS) centers, day programs, and residential long-term care facilities. Mr. Corzo was instrumental in working on the state transition of adult day health care to CBAS. Mr. Corzo also served as the Chair on the OneCare Connect Member Advisory Committee. Mr. Corzo has been a PAC member since 2021.

Behavioral Health Representative
Lorry Leigh Belhumeur, Ph.D.
Dr. Belhumeur has been the Chief Executive Officer of Western Youth Services for over 19 years. She is a licensed psychologist and received her master's and doctoral degrees from UCLA. Western Youth Services provides a range of education, intervention, and treatment to underserved youth and families throughout Orange County. Western Youth Services programs and interventions reach over 50,000 clients each year. Dr. Belhumeur's expertise and passions center around trauma informed care. She has been active in the adverse childhood events community for many years, receiving specialized training in this area. She is a passionate advocate for youth and adults who have experienced traumatic events in

their childhood. Her passion in this area led her to publish a book, "Mastering Resilience: Transforming into your Purpose" last year. The book has already won several awards.

Health Network Representative
Jacob Sweidan, M.D.
Dr. Sweidan is the President at Noble Mid-Orange County, a CalOptima Health contracted health network. He is also a practicing pediatrician with four offices in Anaheim, Garden Grove, and Santa Ana serving CalOptima Health patients since the agency's inception. Dr. Sweidan previously served on the PAC as a Physician Representative and serves on CalOptima Health's Quality Improvement Committee.

Nurse Representative
Tiffany Chou, FNP
Ms. Chou is an Associate Director of Telehealth and a Family Nurse Practitioner at Altamed where she provides direct care to CalOptima Health patients in a clinic and telehealth setting. She supports members in preventative care from birth to elder and women's health and leads a team of providers in supporting telehealth care to improve access and reduce inappropriate emergency room visits to provide 24/7 care to members.

Physician Representative
Morgan Mandigo, M.D.
Dr. Mandigo is an Obstetrician/Gynecologist with St. Jude Neighborhood Health Center where 80-90% of her patients are CalOptima Health members. Dr. Mandigo holds active medical licenses in seven States including California. She is a member of the American College of Obstetricians and Gynecologists (ACOG) committee for underserved women and hopes to highlight statewide women's health initiatives that would benefit CalOptima Health patients. Dr. Mandigo also serves on the District IX Legislative Committee and is also a member of ACOG's committee on Health Care for Underserved Women and Gender Diverse Individuals.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policies AA.1219a, and AA. 1219b, the MAC and PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committees. The MAC and PAC each approved their respective nominations ad hoc subcommittee's recommended slate of candidates at the joint MAC and PAC meeting held June 13, 2024. The MAC and PAC forward their recommended slate of candidates to the Board for their consideration and appointment. The extension of terms for two MAC seats allows the MAC to ensure that the terms are staggered fairly equally when it comes to the yearly recruitment.

Concurrence
Member Advisory Committee Nominations Ad Hoc Subcommittee
Member Advisory Committee
Provider Advisory Committee Nominations Ad Hoc Subcommittee

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

Attachments
None

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

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Financial Summary

May 31, 2024

Board of Directors Meeting
August 1, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights: May 2024

May 2024 Actual	May 2024 Budget	May 2024 $ Variance	May 2024 % Variance		July 2023 - May 2024 Actual	July 2023 - May 2024 Budget	July 2023 - May 2024 $ Variance	July 2023 - May 2024 % Variance
923,029	824,861	98,168	11.9%	Member Months	10,489,525	9,983,506	506,019	5.1%
388,993,781	312,684,759	76,309,022	24.4%	Revenues	4,437,384,901	3,707,628,201	729,756,700	19.7%
351,215,237	303,768,431	(47,446,806)	(15.6%)	Medical Expenses	4,050,601,031	3,491,666,511	(558,934,520)	(16.0%)
20,843,419	23,650,308	2,806,889	11.9%	Administrative Expenses	206,565,120	236,685,604	30,120,484	12.7%
16,935,124	**(14,733,980)**	**31,669,104**	**214.9%**	**Operating Margin**	**180,218,750**	**(20,723,914)**	**200,942,664**	**969.6%**
				Non-Operating Income (Loss)				
19,388,251	2,083,330	17,304,921	830.6%	Net Investment Income/Expense	159,592,790	22,916,630	136,676,160	596.4%
(10,349)	(89,380)	79,031	88.4%	Net Rental Income/Expense	(169,226)	(813,179)	643,953	79.2%
(14,257)	-	(14,257)	(100.0%)	Net MCO Tax	804,033	-	804,033	100.0%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(29,485,861)	(31,035,413)	1,549,552	5.0%
15	-	15	100.0%	Other Income/Expense	(829,913)	-	(829,913)	(100.0%)
19,363,659	**990,731**	**18,372,928**	**1,854.5%**	**Total Non-Operating Income (Loss)**	**129,911,824**	**(8,931,962)**	**138,843,786**	**1,554.5%**
36,298,783	**(13,743,249)**	**50,042,033**	**364.1%**	**Change in Net Assets**	**310,130,573**	**(29,655,876)**	**339,786,449**	**1,145.8%**
90.3%	*97.1%*	*(6.9%)*		*Medical Loss Ratio*	*91.3%*	*94.2%*	*(2.9%)*	
5.4%	*7.6%*	*2.2%*		*Administrative Loss Ratio*	*4.7%*	*6.4%*	*1.7%*	
4.4%	*(4.7%)*	*9.1%*		*Operating Margin Ratio*	*4.1%*	*(0.6%)*	*4.6%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.3%	*97.1%*	*(6.9%)*		**MLR (excluding Directed Payments)*	*90.6%*	*94.2%*	*(3.6%)*	
5.4%	*7.6%*	*2.2%*		**ALR (excluding Directed Payments)*	*5.0%*	*6.4%*	*1.4%*	

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

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Financial Highlights Notes: May 2024

- Notable events/items in May 2024
  - $143.3 million of Hospital Quality Assurance Fee (HQAF) paid out. This was a pass-through item with minimum impact to CalOptima Health’s Change in Net Assets.
  - $16.9 million of Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP) paid out.

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CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) May 2024: $36.3 million, favorable to budget $50.0 million or 364.1%
  - Year To Date (YTD) July 2023 – May 2024: $310.1 million, favorable to budget $339.8 million or 1,145.8% due to favorable performance and net investment income
- Enrollment
  - MTD: 923,029 members, favorable to budget 98,168 or 11.9%
  - YTD: 10,489,525 member months, favorable to budget 506,019 or 5.1%

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $389.0 million, favorable to budget $76.3 million or 24.4% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due to favorable enrollment, membership mix and capitation rates from the Department of Health Care Services (DHCS) and true-up of maternity kick supplemental payments due to logic update
  - YTD: $4,437.4 million, favorable to budget $729.8 million or 19.7%
    - Driven primarily by Hospital Directed Payments (DP), CalAIM Incentive Payment Program (IPP), Housing and Homelessness Incentive Program (HHIP), favorable membership mix and capitation rates from DHCS

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $351.2 million, unfavorable to budget $47.4 million or 15.6%
    - Professional Claims expense unfavorable variance of $29.8 million due to Community Support (CS) services and increased utilization
    - Provider Capitation expense unfavorable variance of $23.1 million due to volume, maternity kick claims true-up and post-Public Health Emergency (PHE) payments
  - YTD: $4,050.6 million, unfavorable to budget $558.9 million or 16.0%
    - Driven primarily by Hospital DP, CS services, post-PHE payments and HHIP

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FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $20.8 million, favorable to budget $2.8 million or 11.9%
  - YTD: $206.6 million, favorable to budget $30.1 million or 12.7%

- Non-Operating Income (Loss)
  - MTD: $19.4 million, favorable to budget $18.4 million or 1,854.5% due primarily to net investment income
  - YTD: $129.9 million, favorable to budget $138.8 million or 1,554.5% due primarily to net investment income

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 90.3% (90.3% excluding DP), Budget 97.1%
  - YTD: Actual 91.3% (90.6% excluding DP), Budget 94.2%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 5.4% (5.4% excluding DP), Budget 7.6%
  - YTD: Actual 4.7% (5.0% excluding DP), Budget 6.4%
- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.76
  - Net-position: $2.0 billion, including required Tangible Net Equity (TNE) of $122.7 million

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

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Enrollment Summary: May 2024

	May 2024				July 2023 - May 2024			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
141,018	132,470	8,548	6.5%	SPD	1,554,619	1,512,550	42,069	2.8%
275,931	269,037	6,894	2.6%	TANF Child	3,194,497	3,244,215	(49,718)	(1.5%)
134,408	125,871	8,537	6.8%	TANF Adult	1,535,052	1,424,412	110,640	7.8%
2,558	3,116	(558)	(17.9%)	LTC	30,418	34,288	(3,870)	(11.3%)
341,555	265,804	75,751	28.5%	MCE	3,859,918	3,447,180	412,738	12.0%
9,913	10,582	(669)	(6.3%)	WCM	117,433	121,135	(3,702)	(3.1%)
905,383	**806,880**	**98,503**	**12.2%**	**Medi-Cal Total**	**10,291,937**	**9,783,780**	**508,157**	**5.2%**
17,159	**17,478**	**(319)**	**(1.8%)**	**OneCare**	**192,598**	**194,491**	**(1,893)**	**(1.0%)**
487	**503**	**(16)**	**(3.2%)**	**PACE**	**4,990**	**5,235**	**(245)**	**(4.7%)**
480	**568**	**(88)**	**(15.5%)**	**MSSP**	**5,410**	**6,248**	**(838)**	**(13.4%)**
923,029	**824,861**	**98,168**	**11.9%**	**CalOptima Health Total**	**10,489,525**	**9,983,506**	**506,019**	**5.1%**

*CalOptima Health Total does not include MSSP

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Consolidated Revenue & Expenses: May 2024 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	563,828	341,555	905,383	17,159		487	480	923,029
REVENUES								
Capitation Revenue	$ 206,521,921	$ 135,642,652	$ 342,164,574	$ 42,519,810	$ -	$ 4,095,439	$ 213,958	$ 388,993,781
Total Operating Revenue	**206,521,921**	**135,642,652**	**342,164,574**	**42,519,810**	**-**	**4,095,439**	**213,958**	**388,993,781**
MEDICAL EXPENSES								
Provider Capitation	65,064,638	48,510,919	113,575,557	19,778,199				133,353,756
Claims	78,045,702	55,354,404	133,400,105	6,285,372	84,435	1,590,519		141,360,432
MLTSS	40,561,103	5,016,851	45,577,954		3,084	(12,041)	31,608	45,600,605
Prescription Drugs	-			9,417,660		583,367		10,001,026
Case Mgmt & Other Medical	10,631,365	6,312,938	16,944,303	2,560,971	(24,904)	1,237,078	181,969	20,899,418
Total Medical Expenses	**194,302,808**	**115,195,112**	**309,497,920**	**38,042,203**	**62,615**	**3,398,924**	**213,576**	**351,215,237**
Medical Loss Ratio	*94.1%*	*84.9%*	*90.5%*	*89.5%*	*0.0%*	*83.0%*	*99.8%*	*90.3%*
GROSS MARGIN	**12,219,114**	**20,447,540**	**32,666,654**	**4,477,607**	**(62,615)**	**696,516**	**382**	**37,778,543**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,870,896	1,067,243		159,354	91,600	13,189,092
Non-Salary Operating Expenses			3,648,976	430,631		144,072	1,333	4,225,012
Depreciation & Amortization			712,940			1,064		714,004
Other Operating Expenses			2,303,489	33,396		8,025	4,022	2,348,932
Indirect Cost Allocation, Occupancy			(610,897)	955,987		15,027	6,263	366,379
Total Administrative Expenses			**17,925,404**	**2,487,256**	**-**	**327,542**	**103,218**	**20,843,419**
Administrative Loss Ratio			*5.2%*	*5.8%*	*0.0%*	*8.0%*	*48.2%*	*5.4%*
Operating Income/(Loss)			**14,741,250**	**1,990,351**	**(62,615)**	**368,974**	**(102,836)**	**16,935,124**
Investments and Other Non-Operating			(14,242)					19,363,659
CHANGE IN NET ASSETS			**$ 14,727,008**	**$ 1,990,351**	**$ (62,615)**	**$ 368,974**	**$ (102,836)**	**$ 36,298,783**
BUDGETED CHANGE IN NET ASSETS			(11,489,591)	(3,059,799)	-	(105,995)	(78,595)	(13,743,249)
Variance to Budget - Fav/(Unfav)			$ 26,216,599	$ 5,050,150	$ (62,615)	$ 474,969	$ (24,241)	$ 50,042,033

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Consolidated Revenue & Expenses: May 2024 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	6,432,019	3,859,918	10,291,937	192,598		4,990	5,410	10,489,525
REVENUES								
Capitation Revenue	$ 2,369,680,844	$ 1,647,539,215	$4,017,220,059	$ 375,990,314	$ (1,367,196)	$ 43,188,193	$ 2,353,532	$ 4,437,384,901
Total Operating Revenue	**2,369,680,844**	**1,647,539,215**	**4,017,220,059**	**375,990,314**	**(1,367,196)**	**43,188,193**	**2,353,532**	**4,437,384,901**
MEDICAL EXPENSES								
Provider Capitation	655,746,996	522,358,085	1,178,105,080	163,037,627				1,341,142,707
Claims	845,294,947	541,698,185	1,386,993,132	71,174,454	117,631	17,725,025		1,476,010,242
MLTSS	472,120,020	61,941,334	534,061,354	-	(18,504)	(10,104)	288,327	534,321,074
Prescription Drugs	(11,660)		(11,660)	89,794,067	(1,822,942)	5,572,178		93,531,642
Case Mgmt & Other Medical	351,461,403	223,681,352	575,142,755	15,978,885	52,408	12,773,031	1,648,287	605,595,366
Total Medical Expenses	**2,324,611,705**	**1,349,678,956**	**3,674,290,661**	**339,985,032**	**(1,671,407)**	**36,060,131**	**1,936,614**	**4,050,601,031**
Medical Loss Ratio	*98.1%*	*81.9%*	*91.5%*	*90.4%*	*122.3%*	*83.5%*	*82.3%*	*91.3%*
GROSS MARGIN	**45,069,138**	**297,860,259**	**342,929,398**	**36,005,281**	**304,210**	**7,128,062**	**416,918**	**386,783,870**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			120,507,827	11,030,264	(0)	1,791,085	1,021,887	134,351,063
Non-Salary Operating Expenses			30,195,236	3,821,406	(4,364)	519,315	14,715	34,546,308
Depreciation & Amortization			7,184,064			12,365		7,196,429
Other Operating Expenses			25,628,740	686,970		93,095	63,310	26,472,115
Indirect Cost Allocation, Occupancy			(6,750,776)	10,515,853		165,238	68,890	3,999,205
Total Administrative Expenses			**176,765,091**	**26,054,492**	**(4,364)**	**2,581,098**	**1,168,803**	**206,565,120**
Administrative Loss Ratio			*4.4%*	*6.9%*	*0.3%*	*6.0%*	*49.7%*	*4.7%*
Operating Income/(Loss)			**166,164,307**	**9,950,789**	**308,575**	**4,546,965**	**(751,885)**	**180,218,750**
Investments and Other Non-Operating			(25,880)					129,911,824
CHANGE IN NET ASSETS			**$ 166,138,427**	**$ 9,950,789**	**$ 308,575**	**$ 4,546,965**	**$ (751,885)**	**$ 310,130,573**
BUDGETED CHANGE IN NET ASSETS			6,083,536	(25,985,673)	-	(11,385)	(810,392)	(29,655,876)
Variance to Budget - Fav/(Unfav)			$ 160,054,891	$ 35,936,462	$ 308,575	$ 4,558,350	$ 58,507	$ 339,786,449

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Balance Sheet: As of May 2024

ASSETS	
Current Assets	
Operating Cash	$942,948,212
Short-term Investments	1,816,280,186
Receivables & Other Current Assets	586,117,414
Total Current Assets	**3,345,345,813**
Capital Assets	
Capital Assets	176,264,688
Less Accumulated Depreciation	(80,373,854)
Capital Assets, Net of Depreciation	95,890,834
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	634,718,531
Total Other Assets	**635,018,531**
TOTAL ASSETS	**4,076,255,178**
Deferred Outflows	**75,969,067**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,152,224,245**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$121,663,608
Medical Claims Liability	1,702,117,420
Capitation and Withholds	168,796,501
Other Current Liabilities	91,446,930
Total Current Liabilities	**2,084,024,458**
Other Liabilities	
GASB 96 Subscription Liabilities	16,955,572
Postemployment Health Care Plan	19,466,727
Net Pension Liabilities	40,465,145
Total Other Liabilities	**76,887,444**
TOTAL LIABILITIES	**2,160,911,902**
Deferred Inflows	**11,175,516**
Net Position	
Required TNE	122,735,327
Funds in Excess of TNE	1,857,401,500
TOTAL NET POSITION	**1,980,136,827**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,152,224,245**

Board Designated Reserve and TNE Analysis: As of May 2024

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	253,044,708				
	Tier 1 - MetLife	250,704,071				
Board Designated Reserve		503,748,780	382,646,422	599,238,601	121,102,358	(95,489,821)
	Tier 2 - Payden & Rygel	65,649,555				
	Tier 2 - MetLife	65,320,196				
TNE Requirement		130,969,751	122,735,327	122,735,327	8,234,424	8,234,424
	Consolidated:	**634,718,531**	**505,381,749**	**721,973,928**	**129,336,782**	**(87,255,397)**
	Current reserve level	*1.76*	*1.40*	*2.00*		

- On May 2, 2024, the Board approved modifications to GA.3001: Statutory and Board-Designated Reserve Funds effective June 1, 2024.

Spending Plan: As of May 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 5/31/2024	**$1,980.1**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$634.7**			**32.1%**
	Capital Assets, net of Depreciation[2]	**$95.9**			**4.8%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.8	$61.7	43.9	0.9%
	Housing and Homelessness Incentive Program[4]	26.5	87.4	60.8	1.3%
	Intergovernmental Transfers (IGT)	59.9	111.7	51.8	3.0%
	Digital Transformation and Workplace Modernization	52.8	100.0	47.2	2.7%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.3	2.0	1.7	0.0%
	CalFresh and Redetermination Outreach Strategy	2.2	6.0	3.8	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	2.0	4.7	2.7	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	138.4	153.5	15.1	7.0%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.5%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.9%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.5%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg. Improvement	10.1	10.5	0.4	0.5%
	Post-Pandemic Supplemental	24.3	107.5	83.2	1.2%
	CalOptima Health Community Reinvestment Program	37.1	38.0	0.9	1.9%
	Outreach Strategy for newly eligible Adult Expansion members	4.5	5.0	0.5	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.2%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	1.0	1.0	0.0	0.1%
	Medi-Cal Provider Rate Increases	526.2	526.2	0.0	26.6%
	Subtotal:	**$1,048.5**	**$1,417.8**	**$369.3**	**52.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$201.1**			**10.2%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 71 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves

Homeless Health Initiative and Allocated Funds: As of May 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	780,255	183,006
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,674
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,088,877	3,987,775
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$43,949,325**	**$57,850,675**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$43,949,325**	**$17,750,675**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

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

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Housing and Homelessness Incentive Program As of May 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	23,648,399	11,552,595	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,845,565	26,538,965	-
Total	**160,315,719**	**122,585,524**	**84,493,965**	**38,091,560**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	418,000	382,000	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013	HHI & DHCS
Infrastructure Projects	5,832,314	5,321,731	510,583	HHI
Capital Projects	98,247,369	73,300,000	24,947,369	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	-	10,184,530	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$84,493,965**	**$38,091,560**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

May 31, 2024

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CalOptima Health - Consolidated
Financial Highlights
For the Eleven Months Ending May 31, 2024

May 2024					July 2023 - May 2024			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
923,029	824,861	98,168	11.9%	Member Months	10,489,525	9,983,506	506,019	5.1%
388,993,781	312,684,759	76,309,022	24.4%	Revenues	4,437,384,901	3,707,628,201	729,756,700	19.7%
351,215,237	303,768,431	(47,446,806)	(15.6%)	Medical Expenses	4,050,601,031	3,491,666,511	(558,934,520)	(16.0%)
20,843,419	23,650,308	2,806,889	11.9%	Administrative Expenses	206,565,120	236,685,604	30,120,484	12.7%
16,935,124	**(14,733,980)**	**31,669,104**	**214.9%**	**Operating Margin**	**180,218,750**	**(20,723,914)**	**200,942,664**	**969.6%**
				Non-Operating Income (Loss)				
19,388,251	2,083,330	17,304,921	830.6%	Net Investment Income/Expense	159,592,790	22,916,630	136,676,160	596.4%
(10,349)	(89,380)	79,031	88.4%	Net Rental Income/Expense	(169,226)	(813,179)	643,953	79.2%
(14,257)	-	(14,257)	(100.0%)	Net MCO Tax	804,033	-	804,033	100.0%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(29,485,861)	(31,035,413)	1,549,552	5.0%
15	-	15	100.0%	Other Income/Expense	(829,913)	-	(829,913)	(100.0%)
19,363,659	**990,731**	**18,372,928**	**1,854.5%**	**Total Non-Operating Income (Loss)**	**129,911,824**	**(8,931,962)**	**138,843,786**	**1,554.5%**
36,298,783	**(13,743,249)**	**50,042,033**	**364.1%**	**Change in Net Assets**	**310,130,573**	**(29,655,876)**	**339,786,449**	**1,145.8%**
90.3%	*97.1%*	*(6.9%)*		*Medical Loss Ratio*	*91.3%*	*94.2%*	*(2.9%)*	
5.4%	*7.6%*	*2.2%*		*Administrative Loss Ratio*	*4.7%*	*6.4%*	*1.7%*	
4.4%	*(4.7%)*	*9.1%*		*Operating Margin Ratio*	*4.1%*	*(0.6%)*	*4.6%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.3%	*97.1%*	*(6.9%)*		**MLR (excluding Directed Payments)*	*90.6%*	*94.2%*	*(3.6%)*	
5.4%	*7.6%*	*2.2%*		**ALR (excluding Directed Payments)*	*5.0%*	*6.4%*	*1.4%*	

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

CalOptima Health - Consolidated
Full Time Employee Data
For the Eleven Months Ending May 31, 2024

Total FTE's MTD	Actual	Budget	Fav/Unfav
Medi-Cal	1,273	1,341	68
OneCare	172	194	22
PACE	105	115	10
MSSP	19	24	5
Total	1,569	1,673	104

Total FTE's YTD	Actual	Budget	Fav/Unfav
Medi-Cal	13,858	14,820	962
OneCare	1,970	2,153	183
PACE	1,155	1,187	32
MSSP	215	259	44
Total	17,197	18,418	1,221

MM per FTE MTD	Actual	Budget	Fav/Unfav
Medi-Cal	711	602	(109)
OneCare	100	90	(10)
PACE	5	4	(1)
MSSP	25	24	(1)
Consolidated	588	493	(95)

MM per FTE YTD	Actual	Budget	Fav/Unfav
Medi-Cal	743	660	(83)
OneCare	98	90	(8)
PACE	4	4	0
MSSP	25	24	(1)
Consolidated	610	542	(68)

Open FTE	Total	Medical	Admin
Medi-Cal	89	37	52
OneCare	9	7	2
PACE	3	2	1
MSSP	2	1	1
Total	103	47	56

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending May 31, 2024

	Actual		Budget		Variance	
MEMBER MONTHS		923,029		824,861		98,168
REVENUE	$	PMPM	$	PMPM	$	PMPM
Medi-Cal	$342,164,574	$377.92	$275,918,587	$341.96	$66,245,987	$35.96
OneCare	42,519,810	2,477.99	32,160,589	1,840.06	10,359,221	637.93
OneCare Connect	-		-		-	-
PACE	4,095,439	8,409.53	4,352,065	8,652.22	(256,626)	(242.69)
MSSP	213,958	445.75	253,518	446.33	(39,560)	(0.58)
Total Operating Revenue	388,993,781	421.43	312,684,759	379.08	76,309,022	42.35
MEDICAL EXPENSES						
Medi-Cal	309,497,920	341.84	267,178,681	331.13	(42,319,239)	(10.71)
OneCare	38,042,203	2,217.04	32,175,233	1,840.90	(5,866,970)	(376.14)
OneCare Connect	62,615				(62,615)	-
PACE	3,398,924	6,979.31	4,195,826	8,341.60	796,902	1,362.29
MSSP	213,576	444.95	218,691	385.02	5,115	(59.93)
Total Medical Expenses	351,215,237	380.50	303,768,431	368.27	(47,446,806)	(12.23)
GROSS MARGIN	37,778,543	40.93	8,916,328	10.81	28,862,215	30.12
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,189,092	14.29	13,256,934	16.07	67,842	1.78
Professional Fees	818,716	0.89	1,401,533	1.70	582,817	0.81
Purchased Services	2,921,510	3.17	3,252,222	3.94	330,712	0.77
Printing & Postage	484,786	0.53	725,114	0.88	240,328	0.35
Depreciation & Amortization	714,004	0.77	400,900	0.49	(313,104)	(0.28)
Other Expenses	2,348,932	2.54	4,168,726	5.05	1,819,794	2.51
Indirect Cost Allocation, Occupancy	366,379	0.40	444,879	0.54	78,500	0.14
Total Administrative Expenses	20,843,419	22.58	23,650,308	28.67	2,806,889	6.09
NET INCOME (LOSS) FROM OPERATIONS	16,935,124	18.35	(14,733,980)	(17.86)	31,669,104	36.21
INVESTMENT INCOME						
Interest Income	15,413,097	16.70	2,083,330	2.53	13,329,767	14.17
Realized Gain/(Loss) on Investments	738,041	0.80	-	-	738,041	0.80
Unrealized Gain/(Loss) on Investments	3,237,113	3.51	-	-	3,237,113	3.51
Total Investment Income	19,388,251	21.01	2,083,330	2.53	17,304,921	18.48
NET RENTAL INCOME/EXPENSE	(10,349)	(0.01)	(89,380)	(0.11)	79,031	0.10
NET MCO TAX	(14,257)	(0.02)	-	-	(14,257)	(0.02)
GRANT EXPENSE	-	-	(1,003,219)	(1.22)	1,003,219	1.22
OTHER INCOME/EXPENSE	15	-	-	-	15	-
CHANGE IN NET ASSETS	**36,298,783**	**39.33**	**(13,743,249)**	**(16.66)**	**50,042,033**	**55.99**
MEDICAL LOSS RATIO	**90.3%**		**97.1%**		**(6.9%)**	
ADMINISTRATIVE LOSS RATIO	**5.4%**		**7.6%**		**2.2%**	

CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

	Actual		Budget		Variance	
MEMBER MONTHS		10,489,525		9,983,506		506,019
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$4,017,220,059	$390.33	$3,308,016,332	$338.11	$709,203,727	$52.22
OneCare	375,990,314	1,952.20	351,804,500	1,808.85	24,185,814	143.35
OneCare Connect	(1,367,196)		-		(1,367,196)	0.00
PACE	43,188,193	8,654.95	45,018,671	8,599.56	(1,830,478)	55.39
MSSP	2,353,532	435.03	2,788,698	446.33	(435,166)	(11.30)
Total Operating Revenue	4,437,384,901	423.03	3,707,628,201	371.38	729,756,700	51.65
MEDICAL EXPENSES						
Medi-Cal	3,674,290,661	357.01	3,098,915,476	316.74	(575,375,185)	(40.27)
OneCare	339,985,032	1,765.26	347,789,530	1,788.20	7,804,498	22.94
OneCare Connect	(1,671,407)				1,671,407	0.00
PACE	36,060,131	7,226.48	42,561,014	8,130.09	6,500,883	903.61
MSSP	1,936,614	357.97	2,400,491	384.20	463,877	26.23
Total Medical Expenses	4,050,601,031	386.16	3,491,666,511	349.74	(558,934,520)	(36.42)
GROSS MARGIN	386,783,870	36.87	215,961,690	21.64	170,822,180	15.23
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	134,351,063	12.81	138,787,207	13.90	4,436,144	1.09
Professional Fees	8,989,050	0.86	12,676,154	1.27	3,687,104	0.41
Purchased Services	19,888,745	1.90	27,536,830	2.76	7,648,085	0.86
Printing & Postage	5,668,513	0.54	6,749,879	0.68	1,081,366	0.14
Depreciation & Amortization	7,196,429	0.69	4,409,900	0.44	(2,786,529)	(0.25)
Other Expenses	26,472,115	2.52	41,631,965	4.17	15,159,850	1.65
Indirect Cost Allocation, Occupancy	3,999,205	0.38	4,893,669	0.49	894,464	0.11
Total Administrative Expenses	206,565,120	19.69	236,685,604	23.71	30,120,484	4.02
NET INCOME (LOSS) FROM OPERATIONS	180,218,750	17.18	(20,723,914)	(2.08)	200,942,664	19.26
INVESTMENT INCOME						
Interest Income	148,615,219	14.17	22,916,630	2.30	125,698,589	11.87
Realized Gain/(Loss) on Investments	(3,266,092)	(0.31)	-	0.00	(3,266,092)	(0.31)
Unrealized Gain/(Loss) on Investments	14,243,663	1.36	-	0.00	14,243,663	1.36
Total Investment Income	159,592,790	15.21	22,916,630	2.30	136,676,160	12.91
NET RENTAL INCOME/EXPENSE	(169,226)	(0.02)	(813,179)	(0.08)	643,953	0.06
NET MCO TAX	804,033	0.08	-	0.00	804,033	0.08
GRANT EXPENSE	(29,485,861)	(2.81)	(31,035,413)	(3.11)	1,549,552	0.30
OTHER INCOME/EXPENSE	(829,913)	(0.08)	-	0.00	(829,913)	(0.08)
CHANGE IN NET ASSETS	**310,130,573**	**29.57**	**(29,655,876)**	**(2.97)**	**339,786,449**	**32.54**
MEDICAL LOSS RATIO	**91.3%**		**94.2%**		**(2.9%)**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**6.4%**		**1.7%**	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending May 31, 2024

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	563,828	341,555	905,383	17,159		487	480	923,029
REVENUES								
Capitation Revenue	$ 206,521,921	$ 135,642,652	$ 342,164,574	$ 42,519,810	$ -	$ 4,095,439	$ 213,958	$ 388,993,781
Total Operating Revenue	**206,521,921**	**135,642,652**	**342,164,574**	**42,519,810**	**-**	**4,095,439**	**213,958**	**388,993,781**
MEDICAL EXPENSES								
Provider Capitation	65,064,638	48,510,919	113,575,557	19,778,199				133,353,756
Claims	78,045,702	55,354,404	133,400,105	6,285,372	84,435	1,590,519		141,360,432
MLTSS	40,561,103	5,016,851	45,577,954		3,084	(12,041)	31,608	45,600,605
Prescription Drugs	-			9,417,660		583,367		10,001,026
Case Mgmt & Other Medical	10,631,365	6,312,938	16,944,303	2,560,971	(24,904)	1,237,078	181,969	20,899,418
Total Medical Expenses	**194,302,808**	**115,195,112**	**309,497,920**	**38,042,203**	**62,615**	**3,398,924**	**213,576**	**351,215,237**
Medical Loss Ratio	*94.1%*	*84.9%*	*90.5%*	*89.5%*	*0.0%*	*83.0%*	*99.8%*	*90.3%*
GROSS MARGIN	**12,219,114**	**20,447,540**	**32,666,654**	**4,477,607**	**(62,615)**	**696,516**	**382**	**37,778,543**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,870,896	1,067,243		159,354	91,600	13,189,092
Non-Salary Operating Expenses			3,648,976	430,631		144,072	1,333	4,225,012
Depreciation & Amortization			712,940			1,064		714,004
Other Operating Expenses			2,303,489	33,396		8,025	4,022	2,348,932
Indirect Cost Allocation, Occupancy			(610,897)	955,987		15,027	6,263	366,379
Total Administrative Expenses			**17,925,404**	**2,487,256**	**-**	**327,542**	**103,218**	**20,843,419**
Administrative Loss Ratio			*5.2%*	*5.8%*	*0.0%*	*8.0%*	*48.2%*	*5.4%*
Operating Income/(Loss)			**14,741,250**	**1,990,351**	**(62,615)**	**368,974**	**(102,836)**	**16,935,124**
Investments and Other Non-Operating			(14,242)					19,363,659
CHANGE IN NET ASSETS			**$ 14,727,008**	**$ 1,990,351**	**$ (62,615)**	**$ 368,974**	**$ (102,836)**	**$ 36,298,783**
BUDGETED CHANGE IN NET ASSETS			(11,489,591)	(3,059,799)	-	(105,995)	(78,595)	(13,743,249)
Variance to Budget - Fav/(Unfav)			$ 26,216,599	$ 5,050,150	$ (62,615)	$ 474,969	$ (24,241)	$ 50,042,033

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ending May 31, 2024

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	6,432,019	3,859,918	10,291,937	192,598		4,990	5,410	10,489,525
REVENUES								
Capitation Revenue	$ 2,369,680,844	$ 1,647,539,215	$ 4,017,220,059	$ 375,990,314	$ (1,367,196)	$ 43,188,193	$ 2,353,532	$ 4,437,384,901
Total Operating Revenue	**2,369,680,844**	**1,647,539,215**	**4,017,220,059**	**375,990,314**	**(1,367,196)**	**43,188,193**	**2,353,532**	**4,437,384,901**
MEDICAL EXPENSES								
Provider Capitation	655,746,996	522,358,085	1,178,105,080	163,037,627				1,341,142,707
Claims	845,294,947	541,698,185	1,386,993,132	71,174,454	117,631	17,725,025		1,476,010,242
MLTSS	472,120,020	61,941,334	534,061,354	-	(18,504)	(10,104)	288,327	534,321,074
Prescription Drugs	(11,660)		(11,660)	89,794,067	(1,822,942)	5,572,178		93,531,642
Case Mgmt & Other Medical	351,461,403	223,681,352	575,142,755	15,978,885	52,408	12,773,031	1,648,287	605,595,366
Total Medical Expenses	**2,324,611,705**	**1,349,678,956**	**3,674,290,661**	**339,985,032**	**(1,671,407)**	**36,060,131**	**1,936,614**	**4,050,601,031**
Medical Loss Ratio	*98.1%*	*81.9%*	*91.5%*	*90.4%*	*122.3%*	*83.5%*	*82.3%*	*91.3%*
GROSS MARGIN	**45,069,138**	**297,860,259**	**342,929,398**	**36,005,281**	**304,210**	**7,128,062**	**416,918**	**386,783,870**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			120,507,827	11,030,264	(0)	1,791,085	1,021,887	134,351,063
Non-Salary Operating Expenses			30,195,236	3,821,406	(4,364)	519,315	14,715	34,546,308
Depreciation & Amortization			7,184,064			12,365		7,196,429
Other Operating Expenses			25,628,740	686,970		93,095	63,310	26,472,115
Indirect Cost Allocation, Occupancy			(6,750,776)	10,515,853		165,238	68,890	3,999,205
Total Administrative Expenses			**176,765,091**	**26,054,492**	**(4,364)**	**2,581,098**	**1,168,803**	**206,565,120**
Administrative Loss Ratio			*4.4%*	*6.9%*	*0.3%*	*6.0%*	*49.7%*	*4.7%*
Operating Income/(Loss)			**166,164,307**	**9,950,789**	**308,575**	**4,546,965**	**(751,885)**	**180,218,750**
Investments and Other Non-Operating			(25,880)					129,911,824
CHANGE IN NET ASSETS			**$ 166,138,427**	**$ 9,950,789**	**$ 308,575**	**$ 4,546,965**	**$ (751,885)**	**$ 310,130,573**
BUDGETED CHANGE IN NET ASSETS			6,083,536	(25,985,673)	-	(11,385)	(810,392)	(29,655,876)
Variance to Budget - Fav/(Unfav)			$ 160,054,891	$ 35,936,462	$ 308,575	$ 4,558,350	$ 58,507	$ 339,786,449

CalOptima Health

Unaudited Financial Statements as of May 31, 2024

MONTHLY RESULTS:

- Change in Net Assets is $36.3 million, favorable to budget $50.0 million
- Operating surplus is $16.9 million, with a surplus in non-operating income of $19.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $310.1 million, $339.8 million favorable to budget
- Operating surplus is $180.2 million, with a surplus in non-operating income of $129.9 million

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

May 2024				July 2023 - May 2024		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
14.7	(11.5)	26.2	Medi-Cal	166.2	6.1	160.1
2.0	(3.1)	5.1	OneCare	10.0	(26.0)	35.9
(0.1)	0.0	(0.1)	OCC	0.3	0.0	0.3
0.4	(0.1)	0.5	PACE	4.5	0.0	4.6
(0.1)	(0.1)	0.0	MSSP	(0.8)	(0.8)	0.1
16.9	**(14.7)**	**31.7**	**Total Operating Income (Loss)**	**180.2**	**(20.7)**	**200.9**
			Non-Operating Income (Loss)			
19.4	2.1	17.3	Net Investment Income/Expense	159.6	22.9	136.7
0.0	(0.1)	0.1	Net Rental Income/Expense	(0.2)	(0.8)	0.6
0.0	0.0	0.0	Net Operating Tax	0.8	0.0	0.8
0.0	(1.0)	1.0	Grant Expense	(29.5)	(31.0)	1.5
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	(0.8)	0.0	(0.8)
19.4	**1.0**	**18.4**	**Total Non-Operating Income/(Loss)**	**129.9**	**(8.9)**	**138.8**
36.3	**(13.7)**	**50.0**	**TOTAL**	**310.1**	**(29.7)**	**339.8**

CalOptima Health - Consolidated
Enrollment Summary
For the Eleven Months Ending May 31, 2024

May 2024					July 2023 - May 2024			
Actual	Budget	$ Variance	%Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	%Variance
141,018	132,470	8,548	6.5%	SPD	1,554,619	1,512,550	42,069	2.8%
275,931	269,037	6,894	2.6%	TANF Child	3,194,497	3,244,215	(49,718)	(1.5%)
134,408	125,871	8,537	6.8%	TANF Adult	1,535,052	1,424,412	110,640	7.8%
2,558	3,116	(558)	(17.9%)	LTC	30,418	34,288	(3,870)	(11.3%)
341,555	265,804	75,751	28.5%	MCE	3,859,918	3,447,180	412,738	12.0%
9,913	10,582	(669)	(6.3%)	WCM	117,433	121,135	(3,702)	(3.1%)
905,383	**806,880**	**98,503**	**12.2%**	**Medi-Cal Total**	**10,291,937**	**9,783,780**	**508,157**	**5.2%**
17,159	**17,478**	**(319)**	**(1.8%)**	**OneCare**	**192,598**	**194,491**	**(1,893)**	**(1.0%)**
487	**503**	**(16)**	**(3.2%)**	**PACE**	**4,990**	**5,235**	**(245)**	**(4.7%)**
480	**568**	**(88)**	**(15.5%)**	**MSSP**	**5,410**	**6,248**	**(838)**	**(13.4%)**
923,029	**824,861**	**98,168**	**11.9%**	**CalOptima Health Total**	**10,489,525**	**9,983,506**	**506,019**	**5.1%**
				Enrollment (by Network)				
300,314	288,492	11,822	4.1%	HMO	3,113,474	3,102,041	11,433	0.4%
180,918	162,781	18,137	11.1%	PHC	2,049,502	1,916,249	133,253	7.0%
145,791	116,802	28,989	24.8%	Shared Risk Group	2,100,398	1,940,188	160,210	8.3%
278,360	238,805	39,555	16.6%	Fee for Service	3,028,563	2,825,302	203,261	7.2%
905,383	**806,880**	**98,503**	**12.2%**	**Medi-Cal Total**	**10,291,937**	**9,783,780**	**508,157**	**5.2%**
17,159	**17,478**	**(319)**	**(1.8%)**	**OneCare**	**192,598**	**194,491**	**(1,893)**	**(1.0%)**
487	**503**	**(16)**	**(3.2%)**	**PACE**	**4,990**	**5,235**	**(245)**	**(4.7%)**
480	**568**	**(88)**	**(15.5%)**	**MSSP**	**5,410**	**6,248**	**(838)**	**(13.4%)**
923,029	**824,861**	**98,168**	**11.9%**	**CalOptima Health Total**	**10,489,525**	**9,983,506**	**506,019**	**5.1%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287	14,179	14,193	14,222	14,337	16,258	16,563	16,462	16,482	16,535		167,785	162,543	5,242
TANF Child	69,607	69,928	69,010	69,620	69,177	68,696	65,998	65,784	76,870	68,123	67,749		760,562	877,133	(116,571)
TANF Adult	50,979	51,388	50,896	50,392	49,538	48,637	61,010	63,447	52,817	59,234	58,001		596,339	604,286	(7,947)
LTC		1			(1)	1	1	1					3		3
MCE	132,523	133,978	131,301	130,441	129,207	127,361	154,424	157,160	159,033	157,664	156,742		1,569,834	1,435,386	134,448
WCM	2,050	2,095	2,021	2,041	2,019	1,982	1,438	1,406	1,301	1,311	1,287		18,951	22,693	(3,742)
Total	269,426	271,677	267,407	266,687	264,162	261,014	299,129	304,361	306,483	302,814	300,314		3,113,474	3,102,041	**11,433**
PHCs															
SPD	4,581	4,599	4,623	4,588	4,705	4,770	4,525	4,754	4,731	4,693	4,701		51,270	46,794	4,476
TANF Child	147,946	148,557	145,969	145,186	144,127	143,149	142,068	141,456	154,158	143,416	142,294		1,598,326	1,524,102	74,224
TANF Adult	8,999	9,050	9,404	8,885	8,692	8,451	8,540	8,619	(4,493)	4,492	4,297		74,936	41,075	33,861
LTC										1			1		1
MCE	23,230	23,489	22,708	22,540	22,400	22,185	22,237	22,769	23,127	22,825	22,989		250,499	228,927	21,572
WCM	6,919	6,974	6,900	6,829	7,044	6,799	6,789	6,585	6,539	6,455	6,637		74,470	75,351	(881)
Total	191,675	192,669	189,604	188,028	186,968	185,354	184,159	184,183	184,062	181,882	180,918		2,049,502	1,916,249	**133,253**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982	10,833	10,803	6,448	6,775	6,798	6,802	6,961		99,860	96,273	3,587
TANF Child	55,211	55,471	54,427	53,505	52,934	52,285	31,419	31,364	36,668	32,982	32,887		489,153	513,555	(24,402)
TANF Adult	43,118	43,425	42,894	42,250	41,524	40,564	26,809	29,619	27,157	30,357	29,636		397,353	341,190	56,163
LTC	1	1			2	2		2		2	2		12		12
MCE	124,149	125,749	122,600	121,935	120,343	117,859	70,007	72,870	76,078	75,930	75,513		1,103,033	977,484	125,549
WCM	1,234	1,247	1,180	1,165	1,190	1,129	800	768	733	749	792		10,987	11,686	(699)
Total	**234,923**	**237,030**	**232,212**	**229,837**	**226,826**	**222,642**	**135,483**	**141,398**	**147,434**	**146,822**	**145,791**		**2,100,398**	**1,940,188**	**160,210**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630	100,115	100,302	93,362	95,142	95,771	96,712	97,782		1,077,640	1,069,102	8,538
TANF Child									6	3	1		10	22	(12)
TANF Adult	2,442	2,397	2,370	2,307	2,247	2,150	1,888	1,694	1,604	1,473	1,381		21,953	27,112	(5,159)
LTC	2,661	2,630	2,612	2,492	2,525	2,421	2,411	2,350	2,239	2,302	2,284		26,927	30,228	(3,301)
MCE	8,968	9,230	9,418	9,312	9,117	8,759	7,761	7,209	6,465	5,971	5,372		87,582	97,591	(10,009)
WCM	15	14	14	13	13	10	6	7	7	6	8		113	198	(85)
Total	**113,328**	**114,103**	**114,164**	**113,754**	**114,017**	**113,642**	**105,428**	**106,402**	**106,092**	**106,467**	**106,828**		**1,214,225**	**1,224,253**	**(10,028)**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921	14,278	14,643	14,683	14,612	14,735	14,899	15,039		158,064	137,838	20,226
TANF Child	29,143	30,159	31,025	29,500	29,973	30,070	31,492	31,523	36,862	33,699	33,000		346,446	329,403	17,043
TANF Adult	37,044	37,794	37,966	37,126	36,903	36,189	54,765	47,862	36,755	40,974	41,093		444,471	410,749	33,722
LTC	349	360	345	327	318	331	316	263	300	294	272		3,475	4,060	(585)
MCE	70,923	73,165	72,983	71,223	71,263	71,175	90,156	84,788	80,568	81,787	80,939		848,970	707,792	141,178
WCM	1,164	1,259	1,212	1,129	1,166	1,114	1,161	1,224	1,126	1,168	1,189		12,912	11,207	1,705
Total	**152,142**	**156,515**	**157,488**	**153,226**	**153,901**	**153,522**	**192,573**	**180,272**	**170,346**	**172,821**	**171,532**		**1,814,338**	**1,601,049**	**213,289**
Grand Totals															
SPD	142,819	143,633	143,620	143,314	144,153	144,855	135,276	137,846	138,497	139,588	141,018		1,554,619	1,512,550	42,069
TANF Child	301,907	304,115	300,431	297,811	296,211	294,200	270,977	270,127	304,564	278,223	275,931		3,194,497	3,244,215	(49,718)
TANF Adult	142,582	144,054	143,530	140,960	138,904	135,991	153,012	151,241	113,840	136,530	134,408		1,535,052	1,424,412	110,640
LTC	3,011	2,992	2,957	2,819	2,844	2,755	2,728	2,616	2,539	2,599	2,558		30,418	34,288	(3,870)
MCE	359,793	365,611	359,010	355,451	352,330	347,339	344,585	344,796	345,271	344,177	341,555		3,859,918	3,447,180	412,738
WCM	11,382	11,589	11,327	11,177	11,432	11,034	10,194	9,990	9,706	9,689	9,913		117,433	121,135	(3,702)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**	**945,874**	**936,174**	**916,772**	**916,616**	**914,417**	**910,806**	**905,383**		**10,291,937**	**9,783,780**	**508,157**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**	**17,648**	**17,593**	**17,380**	**17,300**	**17,277**	**17,138**	**17,159**		**192,598**	**194,491**	**(1,893)**
PACE	**429**	**432**	**437**	**442**	**446**	**447**	**453**	**457**	**474**	**486**	**487**		**4,990**	**5,235**	**(245)**
MSSP	**503**	**500**	**503**	**494**	**491**	**494**	**492**	**488**	**484**	**481**	**480**		**5,410**	**6,248**	**(838)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**	**963,968**	**954,214**	**934,605**	**934,373**	**932,168**	**928,430**	**923,029**		**10,489,525**	**9,983,506**	**506,019**

Note:* Total membership does not include MSSP

ENROLLMENT:

Overall, May enrollment was 923,029

- Favorable to budget 98,168 or 11.9%
- Decreased 5,401 from Prior Month (PM) (April 2024)
- Decreased 67,157 or 6.8% from Prior Year (PY) (May 2023)

Medi-Cal enrollment was 905,383

- Favorable to budget 98,503 or 12.2% due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts.
- Medi-Cal Expansion (MCE) favorable to budget 75,751
- Temporary Assistance for Needy Families (TANF) favorable to budget 15,431
- Seniors and Persons with Disabilities (SPD) favorable to budget 8,548
- Whole Child Model (WCM) unfavorable to budget 669
- Long-Term Care (LTC) unfavorable to budget 558
- Decreased 5,423 from PM

OneCare enrollment was 17,159

- Unfavorable to budget 319 or 1.8%
- Increased 21 from PM

PACE enrollment was 487

- Unfavorable to budget 16 or 3.2%
- Increased 1 from PM

MSSP enrollment was 480

- Unfavorable to budget 88 or 15.5% due to MSSP currently being understaffed. There is a staff to member ratio that must be met.
- Decreased 1 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
905,383	**806,880**	**98,503**	**12.2%**	**Member Months**	**10,291,937**	**9,783,780**	**508,157**	**5.2%**
				Revenues				
342,164,574	275,918,587	66,245,987	24.0%	Medi-Cal Capitation Revenue	4,017,220,059	3,308,016,332	709,203,727	21.4%
342,164,574	**275,918,587**	**66,245,987**	**24.0%**	**Total Operating Revenue**	**4,017,220,059**	**3,308,016,332**	**709,203,727**	**21.4%**
				Medical Expenses				
113,575,557	95,109,627	(18,465,930)	(19.4%)	Provider Capitation	1,178,105,080	1,116,277,114	(61,827,966)	(5.5%)
60,967,840	63,242,496	2,274,656	3.6%	Facilities Claims	733,087,409	763,641,281	30,553,872	4.0%
72,432,266	42,835,815	(29,596,451)	(69.1%)	Professional Claims	653,905,723	492,930,754	(160,974,969)	(32.7%)
45,577,954	51,099,086	5,521,132	10.8%	MLTSS	534,061,354	559,082,193	25,020,839	4.5%
-	-	-	0.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
7,431,025	5,704,676	(1,726,349)	(30.3%)	Incentive Payments	166,003,167	71,488,672	(94,514,495)	(132.2%)
7,319,167	8,198,174	879,007	10.7%	Medical Management	75,998,596	84,455,419	8,456,823	10.0%
2,194,111	988,807	(1,205,304)	(121.9%)	Other Medical Expenses	333,140,992	11,040,043	(322,100,949)	(2,917.6%)
309,497,920	**267,178,681**	**(42,319,239)**	**(15.8%)**	**Total Medical Expenses**	**3,674,290,661**	**3,098,915,476**	**(575,375,185)**	**(18.6%)**
32,666,654	**8,739,906**	**23,926,748**	**273.8%**	**Gross Margin**	**342,929,398**	**209,100,856**	**133,828,542**	**64.0%**
				Administrative Expenses				
11,870,896	11,709,097	(161,799)	(1.4%)	Salaries, Wages & Employee Benefits	120,507,827	122,828,434	2,320,607	1.9%
786,377	1,225,796	439,419	35.8%	Professional Fees	8,238,139	11,778,047	3,539,908	30.1%
2,475,329	2,878,037	402,708	14.0%	Purchased Services	17,453,968	24,309,728	6,855,760	28.2%
387,270	526,030	138,760	26.4%	Printing & Postage	4,503,129	5,009,670	506,541	10.1%
712,940	400,000	(312,940)	(78.2%)	Depreciation & Amortization	7,184,064	4,400,000	(2,784,064)	(63.3%)
2,303,489	4,016,628	1,713,139	42.7%	Other Operating Expenses	25,628,740	40,478,442	14,849,702	36.7%
(610,897)	(526,091)	84,806	16.1%	Indirect Cost Allocation, Occupancy	(6,750,776)	(5,787,001)	963,775	16.7%
17,925,404	**20,229,497**	**2,304,093**	**11.4%**	**Total Administrative Expenses**	**176,765,091**	**203,017,320**	**26,252,229**	**12.9%**
				Non-Operating Income (Loss)				
(14,257)	-	(14,257)	(100.0%)	Net Operating Tax	804,033	-	804,033	100.0%
15	-	15	100.0%	Other Income/Expense	(829,913)	-	(829,913)	(100.0%)
(14,242)	**-**	**(14,242)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(25,880)**	**-**	**(25,880)**	**(100.0%)**
14,727,008	**(11,489,591)**	**26,216,599**	**228.2%**	**Change in Net Assets**	**166,138,427**	**6,083,536**	**160,054,891**	**2,631.0%**
90.5%	***96.8%***	***(6.4%)***		***Medical Loss Ratio***	***91.5%***	***93.7%***	***(2.2%)***	
5.2%	***7.3%***	***2.1%***		***Admin Loss Ratio***	***4.4%***	***6.1%***	***1.7%***	

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES of $342.2 million are favorable to budget $66.2 million driven by:

- Favorable volume related variance of $33.7 million
- Favorable price related variance of $32.6 million
  - $18.8 million due to favorable capitation rates and enrollment mix
  - $18.1 million due to logic update for maternity kick supplemental payments
  - Offset by $3.9 million from Enhanced Care Management (ECM) and Proposition 56 risk corridors

MEDICAL EXPENSES of $309.5 million are unfavorable to budget $42.3 million driven by:

- Unfavorable volume related variance of $32.6 million
- Unfavorable price related variance of $9.7 million
  - Professional Claims expense unfavorable variance of $24.4 million due primarily to Community Support (CS) services and increase in utilization
  - Provider Capitation expense unfavorable variance of $6.9 million due to maternity kick claims true-up due to logic update and post-Public Health Emergency (PHE) payments
  - Other Medical expense unfavorable variance of $1.1 million
  - Incentive Payments expense unfavorable variance of $1.0 million
  - Offset by:
    - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $11.8 million due to lower than expected utilization
    - Facilities Claims expense favorable variance of $10.0 million
    - Medical Management expense favorable variance of $1.9 million

ADMINISTRATIVE EXPENSES of $17.9 million are favorable to budget $2.3 million driven by:

- Non-Salary expenses favorable to budget $2.5 million
- Salaries, Wages & Employee Benefits expense unfavorable to budget $0.2 million

CHANGE IN NET ASSETS is $14.7 million, favorable to budget $26.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,159	**17,478**	**(319)**	**(1.8%)**	**Member Months**	**192,598**	**194,491**	**(1,893)**	**(1.0%)**
				Revenues				
32,848,098	23,421,457	9,426,641	40.2%	Medicare Part C Revenue	281,412,087	255,348,003	26,064,084	10.2%
9,671,711	8,739,132	932,579	10.7%	Medicare Part D Revenue	94,578,226	96,456,497	(1,878,271)	(1.9%)
42,519,810	**32,160,589**	**10,359,221**	**32.2%**	**Total Operating Revenue**	**375,990,314**	**351,804,500**	**24,185,814**	**6.9%**
				Medical Expenses				
19,778,199	15,173,315	(4,604,884)	(30.3%)	Provider Capitation	163,037,627	155,179,360	(7,858,267)	(5.1%)
4,424,118	3,848,362	(575,756)	(15.0%)	Inpatient	53,710,708	50,382,769	(3,327,939)	(6.6%)
1,861,254	1,267,772	(593,482)	(46.8%)	Ancillary	17,463,746	15,017,976	(2,445,770)	(16.3%)
-	80,574	80,574	100.0%	MLTSS	-	896,602	896,602	100.0%
9,417,660	10,192,475	774,815	7.6%	Prescription Drugs	89,794,067	108,502,496	18,708,429	17.2%
1,558,024	322,349	(1,235,675)	(383.3%)	Incentive Payments	4,992,455	4,009,838	(982,617)	(24.5%)
1,002,947	1,290,386	287,439	22.3%	Medical Management	10,985,079	13,800,489	2,815,410	20.4%
-	-	-	0.0%	Other Medical Expenses	1,350	-	(1,350)	(100.0%)
38,042,203	**32,175,233**	**(5,866,970)**	**(18.2%)**	**Total Medical Expenses**	**339,985,032**	**347,789,530**	**7,804,498**	**2.2%**
4,477,607	**(14,644)**	**4,492,251**	**30,676.4%**	**Gross Margin**	**36,005,281**	**4,014,970**	**31,990,311**	**796.8%**
				Administrative Expenses				
1,067,243	1,230,589	163,346	13.3%	Salaries, Wages & Employee Benefits	11,030,264	12,933,620	1,903,356	14.7%
31,006	169,500	138,494	81.7%	Professional Fees	416,530	829,500	412,971	49.8%
302,109	357,728	55,619	15.5%	Purchased Services	2,250,438	3,111,078	860,640	27.7%
97,516	204,347	106,831	52.3%	Printing & Postage	1,154,438	1,723,102	568,664	33.0%
33,396	134,408	101,012	75.2%	Other Operating Expenses	686,970	968,930	281,960	29.1%
955,987	948,583	(7,404)	(0.8%)	Indirect Cost Allocation, Occupancy	10,515,853	10,434,413	(81,440)	(0.8%)
2,487,256	**3,045,155**	**557,899**	**18.3%**	**Total Administrative Expenses**	**26,054,492**	**30,000,643**	**3,946,151**	**13.2%**
1,990,351	**(3,059,799)**	**5,050,150**	**165.0%**	**Change in Net Assets**	**9,950,789**	**(25,985,673)**	**35,936,462**	**138.3%**
89.5%	*100.0%*	*(10.6%)*		***Medical Loss Ratio***	*90.4%*	*98.9%*	*(8.4%)*	
5.8%	*9.5%*	*3.6%*		***Admin Loss Ratio***	*6.9%*	*8.5%*	*1.6%*	

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ONECARE INCOME STATEMENT– MAY MONTH:

REVENUES of $42.5 million are favorable to budget $10.4 million driven by:

- Unfavorable volume related variance of $0.6 million
- Favorable price related variance of $10.9 million due to Calendar Year (CY) 2023 Hierarchical Condition Category (HCC)

MEDICAL EXPENSES of $38.0 million are unfavorable to budget $5.9 million driven by:

- Favorable volume related variance of $0.6 million
- Unfavorable price related variance of $6.5 million
  - ➢ Provider Capitation expense unfavorable variance of $4.9 million due to CY 2023 HCC
  - ➢ Incentive Payments expense unfavorable variance of $1.2 million
  - ➢ Offset by all other expenses net unfavorable variance of $0.3 million

ADMINISTRATIVE EXPENSES of $2.5 million are favorable to budget $0.6 million driven by:

- Non-Salary expenses favorable to budget $0.4 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $2.0 million, favorable to budget $5.1 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Revenue	22,753	-	22,753	100.0%
-	-	-	0.0%	Medicare Part D Revenue	(1,389,949)	-	(1,389,949)	(100.0%)
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**(1,367,196)**	**-**	**(1,367,196)**	**(100.0%)**
				Medical Expenses				
101,257	-	(101,257)	(100.0%)	Facilities Claims	(468,224)	-	468,224	100.0%
(16,822)	-	16,822	100.0%	Ancillary	585,855	-	(585,855)	(100.0%)
3,084	-	(3,084)	(100.0%)	MLTSS	(18,504)	-	18,504	100.0%
-	-	-	0.0%	Prescription Drugs	(1,822,942)	-	1,822,942	100.0%
(24,904)	-	24,904	100.0%	Incentive Payments	105,010	-	(105,010)	(100.0%)
-	-	-	0.0%	Medical Management	(52,602)	-	52,602	100.0%
62,615	**-**	**(62,615)**	**(100.0%)**	**Total Medical Expenses**	**(1,671,407)**	**-**	**1,671,407**	**100.0%**
(62,615)	**-**	**(62,615)**	**(100.0%)**	**Gross Margin**	**304,210**	**-**	**304,210**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Purchased Services	(4,364)	-	4,364	100.0%
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**(4,364)**	**-**	**4,364**	**100.0%**
(62,615)	**-**	**(62,615)**	**(100.0%)**	**Change in Net Assets**	**308,575**	**-**	**308,575**	**100.0%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***122.3%***	***0.0%***	***122.3%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
487	**503**	**(16)**	**(3.2%)**	**Member Months**	**4,990**	**5,235**	**(245)**	**(4.7%)**
				Revenues				
3,094,620	3,280,439	(185,819)	(5.7%)	Medi-Cal Capitation Revenue	32,075,370	34,037,241	(1,961,871)	(5.8%)
731,791	841,737	(109,946)	(13.1%)	Medicare Part C Revenue	8,140,345	8,588,837	(448,492)	(5.2%)
269,028	229,889	39,139	17.0%	Medicare Part D Revenue	2,972,478	2,392,593	579,885	24.2%
4,095,439	**4,352,065**	**(256,626)**	**(5.9%)**	**Total Operating Revenue**	**43,188,193**	**45,018,671**	**(1,830,478)**	**(4.1%)**
				Medical Expenses				
1,237,078	1,331,273	94,195	7.1%	Medical Management	12,773,031	13,550,599	777,568	5.7%
742,597	1,002,101	259,504	25.9%	Facilities Claims	7,698,150	10,179,254	2,481,104	24.4%
661,156	914,222	253,066	27.7%	Professional Claims	7,568,790	9,621,582	2,052,792	21.3%
583,367	530,593	(52,774)	(9.9%)	Prescription Drugs	5,572,178	5,257,089	(315,089)	(6.0%)
(12,041)	127,865	139,906	109.4%	MLTSS	(10,104)	1,327,467	1,337,571	100.8%
186,767	289,772	103,005	35.5%	Patient Transportation	2,458,086	2,625,023	166,937	6.4%
3,398,924	**4,195,826**	**796,902**	**19.0%**	**Total Medical Expenses**	**36,060,131**	**42,561,014**	**6,500,883**	**15.3%**
696,516	**156,239**	**540,277**	**345.8%**	**Gross Margin**	**7,128,062**	**2,457,657**	**4,670,405**	**190.0%**
				Administrative Expenses				
159,354	220,127	60,773	27.6%	Salaries, Wages & Employee Benefits	1,791,085	2,005,865	214,780	10.7%
-	4,904	4,904	100.0%	Professional Fees	319,715	53,944	(265,771)	(492.7%)
144,072	16,457	(127,615)	(775.4%)	Purchased Services	188,654	116,024	(72,630)	(62.6%)
-	(5,263)	(5,263)	100.0%	Printing & Postage	10,946	17,107	6,161	36.0%
1,064	900	(164)	(18.2%)	Depreciation & Amortization	12,365	9,900	(2,465)	(24.9%)
8,025	10,247	2,222	21.7%	Other Operating Expenses	93,095	102,720	9,625	9.4%
15,027	14,862	(165)	(1.1%)	Indirect Cost Allocation, Occupancy	165,238	163,482	(1,756)	(1.1%)
327,542	**262,234**	**(65,308)**	**(24.9%)**	**Total Administrative Expenses**	**2,581,098**	**2,469,042**	**(112,056)**	**(4.5%)**
368,974	**(105,995)**	**474,969**	**448.1%**	**Change in Net Assets**	**4,546,965**	**(11,385)**	**4,558,350**	**40,038.2%**
83.0%	***96.4%***	***(13.4%)***		***Medical Loss Ratio***	***83.5%***	***94.5%***	***(11.0%)***	
8.0%	***6.0%***	***(2.0%)***		***Admin Loss Ratio***	***6.0%***	***5.5%***	***(0.5%)***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
480	**568**	**(88)**	**(15.5%)**	**Member Months**	**5,410**	**6,248**	**(838)**	**(13.4%)**
				Revenues				
213,958	253,518	(39,560)	(15.6%)	Revenue	2,353,532	2,788,698	(435,166)	(15.6%)
213,958	**253,518**	**(39,560)**	**(15.6%)**	**Total Operating Revenue**	**2,353,532**	**2,788,698**	**(435,166)**	**(15.6%)**
				Medical Expenses				
181,969	185,734	3,765	2.0%	Medical Management	1,648,287	2,037,964	389,677	19.1%
31,608	32,957	1,349	4.1%	Waiver Services	288,327	362,527	74,200	20.5%
181,969	185,734	3,765	2.0%	Total Medical Management	1,648,287	2,037,964	389,677	19.1%
31,608	32,957	1,349	4.1%	Total Waiver Services	288,327	362,527	74,200	20.5%
213,576	**218,691**	**5,115**	**2.3%**	**Total Program Expenses**	**1,936,614**	**2,400,491**	**463,877**	**19.3%**
382	**34,827**	**(34,445)**	**(98.9%)**	**Gross Margin**	**416,918**	**388,207**	**28,711**	**7.4%**
				Administrative Expenses				
91,600	97,121	5,521	5.7%	Salaries, Wages & Employee Benefits	1,021,887	1,019,288	(2,599)	(0.3%)
1,333	1,333	(0)	(0.0%)	Professional Fees	14,667	14,663	(4)	(0.0%)
-	-	-	0.0%	Purchased Services	48	-	(48)	(100.0%)
4,022	7,443	3,421	46.0%	Other Operating Expenses	63,310	81,873	18,563	22.7%
6,263	7,525	1,262	16.8%	Indirect Cost Allocation, Occupancy	68,890	82,775	13,885	16.8%
103,218	**113,422**	**10,204**	**9.0%**	**Total Administrative Expenses**	**1,168,803**	**1,198,599**	**29,796**	**2.5%**
(102,836)	**(78,595)**	**(24,241)**	**(30.8%)**	**Change in Net Assets**	**(751,885)**	**(810,392)**	**58,507**	**7.2%**
99.8%	***86.3%***	***13.6%***		***Medical Loss Ratio***	***82.3%***	***86.1%***	***(3.8%)***	
48.2%	***44.7%***	***(3.5%)***		***Admin Loss Ratio***	***49.7%***	***43.0%***	***(6.7%)***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
50,530	50,473	(57)	(0.1%)	Purchased Services	497,563	440,803	(56,760)	(12.9%)
181,456	211,000	29,544	14.0%	Depreciation & Amortization	1,966,380	2,321,000	354,620	15.3%
24,795	34,000	9,205	27.1%	Insurance Expense	254,413	374,000	119,587	32.0%
114,938	138,702	23,764	17.1%	Repair & Maintenance	1,336,705	1,640,122	303,417	18.5%
43,088	57,859	14,771	25.5%	Other Operating Expenses	618,208	636,449	18,241	2.9%
(414,806)	(492,034)	(77,228)	(15.7%)	Indirect Cost Allocation, Occupancy	(4,673,269)	(5,412,374)	(739,105)	(13.7%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
156,423	133,810	22,613	16.9%	Rental Income	1,724,743	1,471,910	252,833	17.2%
156,423	**133,810**	**22,613**	**16.9%**	**Total Operating Revenue**	**1,724,743**	**1,471,910**	**252,833**	**17.2%**
				Administrative Expenses				
29,318	31,141	1,823	5.9%	Purchased Services	322,887	246,491	(76,396)	(31.0%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	380,302	440,000	59,698	13.6%
8,459	10,091	1,632	16.2%	Insurance Expense	86,380	111,001	24,621	22.2%
38,432	60,845	22,413	36.8%	Repair & Maintenance	481,123	765,355	284,232	37.1%
19,369	24,446	5,077	20.8%	Other Operating Expenses	248,898	268,906	20,008	7.4%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
130,151	**166,523**	**36,372**	**21.8%**	**Total Administrative Expenses**	**1,519,589**	**1,831,753**	**312,164**	**17.0%**
26,272	**(32,713)**	**58,985**	**180.3%**	**Change in Net Assets**	**205,154**	**(359,843)**	**564,997**	**157.0%**

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
60,434	56,667	(3,767)	(6.6%)	Purchased Services	207,447	453,336	245,889	54.2%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	75,179	-	(75,179)	(100.0%)
4,415	-	(4,415)	(100.0%)	Insurance Expense	35,317	-	(35,317)	(100.0%)
(38,077)	-	38,077	100.0%	Repair & Maintenance	45,620	-	(45,620)	(100.0%)
452	-	(452)	(100.0%)	Other Operating Expenses	10,816	-	(10,816)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
36,621	**56,667**	**20,046**	**35.4%**	**Total Administrative Expenses**	**374,380**	**453,336**	**78,956**	**17.4%**
(36,621)	**(56,667)**	**20,046**	**35.4%**	**Change in Net Assets**	**(374,380)**	**(453,336)**	**78,956**	**17.4%**

OTHER PROGRAM INCOME STATEMENTS – MAY MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is ($62,615), unfavorable to budget $62,615 due to PY activities

PACE

- **CHANGE IN NET ASSETS** is $0.4 million, favorable to budget $0.5 million

MSSP

- **CHANGE IN NET ASSETS** is ($102,836), unfavorable to budget $24,241

NON-OPERATING INCOME STATEMENTS – MAY MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is $26,272, favorable to budget $58,985
  - Net of $156,423 in rental income and $130,151 in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($36,621), favorable to budget $20,046

INVESTMENT INCOME

- Favorable variance of $17.3 million due to $13.3 million of interest income and $4.0 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
May 31, 2024

	May-24	April-24	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	942,948,212	941,163,737	1,784,476	0.2%
Short-term Investments	1,816,280,186	1,905,883,695	(89,603,509)	(4.7%)
Premiums due from State of CA and CMS	572,403,715	689,120,563	(116,716,848)	(16.9%)
Prepaid Expenses and Other	13,713,699	15,369,375	(1,655,676)	(10.8%)
Total Current Assets	**3,345,345,813**	**3,551,537,370**	**(206,191,557)**	**(5.8%)**
Board Designated Assets				
Cash and Cash Equivalents	2,085,441	8,475,941	(6,390,500)	(75.4%)
Investments	632,633,090	621,341,101	11,291,989	1.8%
Total Board Designated Assets	**634,718,531**	**629,817,043**	**4,901,489**	**0.8%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**95,890,834**	**96,135,905**	**(245,071)**	**(0.3%)**
Total Assets	**4,076,255,178**	**4,277,790,317**	**(201,535,139)**	**(4.7%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
Net Pension	24,373,350	24,373,350	-	0.0%
Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
Total Deferred Outflows of Resources	**75,969,067**	**75,969,067**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,152,224,245**	**4,353,759,384**	**(201,535,139)**	**(4.6%)**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,692,431,791	1,921,514,612	(229,082,821)	(11.9%)
Provider Capitation and Withholds	168,796,501	150,416,305	18,380,196	12.2%
Accrued Reinsurance Costs to Providers	9,685,629	8,382,295	1,303,334	15.5%
Unearned Revenue	72,822,274	20,086,592	52,735,682	262.5%
Accounts Payable and Other	121,663,608	199,567,396	(77,903,788)	(39.0%)
Accrued Payroll and Employee Benefits and Other	18,604,710	21,908,769	(3,304,059)	(15.1%)
Deferred Lease Obligations	19,946	23,224	(3,279)	(14.1%)
Total Current Liabilities	**2,084,024,458**	**2,321,899,193**	**(237,874,735)**	**(10.2%)**
GASB 96 Subscription Liabilities	16,955,572	16,955,572	-	0.0%
Postemployment Health Care Plan	19,466,727	19,425,914	40,813	0.2%
Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities	**2,160,911,902**	**2,398,745,824**	**(237,833,922)**	**(9.9%)**
Deferred Inflows of Resources				
Net Pension	3,387,516	3,387,516	-	0.0%
Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position				
Required TNE	122,735,327	121,870,721	864,606	0.7%
Funds in excess of TNE	1,857,401,500	1,821,967,323	35,434,177	1.9%
Total Net Position	**1,980,136,827**	**1,943,838,044**	**36,298,783**	**1.9%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,152,224,245**	**4,353,759,384**	**(201,535,139)**	**(4.6%)**

BALANCE SHEET – MAY MONTH:

ASSETS of $4.2 billion decreased $201.5 million from April or 4.6%

- Premiums due from the State of California (CA) and the Centers for Medicare & Medicaid Services (CMS) decreased $116.7 million due primarily to receipt of CY 2024 Managed Care Organization (MCO) tax
- Operating Cash and Short-term Investments net decrease of $87.8 million due to Hospital Quality Assurance Fee (HQAF) Payment of $143.0 million, offset by receipt of CMS advance payment of $53.0 million

LIABILITIES of $2.2 billion decreased $237.8 million from April or 9.9%

- Medical Claims Liabilities decreased $229.1 million due to HQAF payment of $143.0 million, Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIF) payment of $16.9 million, Bridge Period Proposition 56 payment of $6.4 million and CY 2021 Proposition 56 payment of $47.2 million
- Accounts Payable and Other decreased $77.9 million due primarily to the MCO tax liability and related payments
- Provider Capitation and Withholds increased $18.4 million due primarily to maternity kick claims true-up, CY 2023 HCC estimates and timing of capitation payments
- Unearned Revenue increased $52.7 million due to timing of capitation payments from CMS

NET ASSETS of $2.0 billion, increased $36.3 million from April or 1.9%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of May 31, 2024

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	253,044,708				
	Tier 1 - MetLife	250,704,071				
Board Designated Reserve		503,748,780	382,646,422	599,238,601	121,102,358	(95,489,821)
	Tier 2 - Payden & Rygel	65,649,555				
	Tier 2 - MetLife	65,320,196				
TNE Requirement		130,969,751	122,735,327	122,735,327	8,234,424	8,234,424
	Consolidated:	**634,718,531**	**505,381,749**	**721,973,928**	**129,336,782**	**(87,255,397)**
	Current reserve level	*1.76*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flow
May 31, 2024

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	36,298,783	310,130,573
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	939,431	9,618,290
Changes in assets and liabilities:		
Prepaid expenses and other	1,655,676	1,347,003
Capitation receivable	116,716,848	(98,480,017)
Medical claims liability	(227,779,487)	61,878,656
Deferred revenue	52,735,682	9,379,362
Payable to health networks	18,380,196	43,352,475
Accounts payable	(77,903,788)	106,581,665
Accrued payroll	(3,263,246)	(4,235,954)
Other accrued liabilities	(3,279)	812,494
Net cash provided by/(used in) operating activities	(82,223,184)	440,384,548
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	(49,999,717)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	89,603,509	(139,544,122)
Change in Property and Equipment	(694,360)	(21,301,620)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(4,901,489)	(58,166,837)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	84,007,660	(219,012,579)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	1,784,476	171,372,252
CASH AND CASH EQUIVALENTS, beginning of period	$941,163,737	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**942,948,212**	**942,948,212**

CalOptima Health
Spending Plan
For the Eleven Months Ending May 31, 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 5/31/2024	**$1,980.1**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$634.7**			**32.1%**
	Capital Assets, net of Depreciation[2]	**$95.9**			**4.8%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.8	$61.7	43.9	0.9%
	Housing and Homelessness Incentive Program[4]	26.5	87.4	60.8	1.3%
	Intergovernmental Transfers (IGT)	59.9	111.7	51.8	3.0%
	Digital Transformation and Workplace Modernization	52.8	100.0	47.2	2.7%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.3	2.0	1.7	0.0%
	CalFresh and Redetermination Outreach Strategy	2.2	6.0	3.8	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	2.0	4.7	2.7	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	138.4	153.5	15.1	7.0%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.5%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.9%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.5%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg. Improvement	10.1	10.5	0.4	0.5%
	Post-Pandemic Supplemental	24.3	107.5	83.2	1.2%
	CalOptima Health Community Reinvestment Program	37.1	38.0	0.9	1.9%
	Outreach Strategy for newly eligible Adult Expansion members	4.5	5.0	0.5	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.2%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	1.0	1.0	0.0	0.1%
	Medi-Cal Provider Rate Increases	526.2	526.2	0.0	26.6%
	Subtotal:	**$1,048.5**	**$1,417.8**	**$369.3**	**52.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$201.1**			**10.2%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 71 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves

CalOptima Health
Key Financial Indicators
As of May 31, 2024

	Item Name	May 2024					July 2023 - May 2024				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	923,029	824,861	98,168	11.9%	Green	10,489,525	9,983,506	506,019	5.1%	Green
	Operating Revenue	388,993,781	312,684,759	76,309,022	24.4%	Green	4,437,384,901	3,707,628,201	729,756,700	19.7%	Green
	Medical Expenses	351,215,237	303,768,431	(47,446,806)	(15.6%)	Yellow	4,050,601,031	3,491,666,511	(558,934,520)	(16.0%)	Yellow
	General and Administrative Expense	20,843,419	23,650,308	2,806,889	11.9%	Green	206,565,120	236,685,604	30,120,484	12.7%	Green
	Non-Operating Income/(Loss)	19,363,659	990,731	18,372,928	1,854.5%	Green	129,911,824	(8,931,962)	138,843,785	1,554.5%	Green
	Summary of Income & Expenses	36,298,783	(13,743,249)	50,042,033	364.1%	Green	310,130,573	(29,655,876)	339,786,449	1,145.8%	Green
Ratios	**Medical Loss Ratio (MLR)**	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	90.3%	97.1%	(6.9%)		Yellow	91.3%	94.2%	(2.9%)		Yellow
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	5.4%	7.6%	2.2%		Green	4.7%	6.4%	1.7%		Green

Key:

> 0%	Green
> -20%, < 0%	Yellow
< -20%	Red

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@5/31/2024*	2,429,246,757	2,508,317,343	(79,070,586)	(3.2%)
	Unallocated/Unassigned Reserve Balance	**Current Month @ May 2024**	**Fiscal Year Ending June 2023**	**Change**	**%**
	Consolidated	201,069,365	354,771,258	(153,701,894)	(43.3%)
	*Days Cash On Hand**	71			

*Total of Board Designated reserve and unallocated reserve amount can support approximatley 71 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eleven Months Ending May 31, 2024

	May 2024				July 2023 - May 2024				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**244,838**	**1,450,664**	**1,205,826**	**83.1%**	**18,945,728**	**18,693,304**	**(252,424)**	**(1.4%)**	**22,543,779**	**55,539,304**	**32,995,525**	**59.4%**
Operating Expenses:												
Salaries, Wages & Benefits	685,340	609,649	(75,691)	(12.4%)	6,958,492	6,706,139	(252,353)	(3.8%)	10,377,069	11,998,372	1,621,303	13.5%
Professional Fees	70,000	307,916	237,916	77.3%	1,266,733	2,167,076	900,343	41.5%	1,532,926	4,399,576	2,866,650	65.2%
Purchased Services	69,041	155,000	85,959	55.5%	69,041	1,705,000	1,635,959	96.0%	69,041	2,015,000	1,945,959	96.6%
Other Expenses	993,950	1,881,009	887,059	47.2%	9,638,516	16,471,099	6,832,583	41.5%	12,653,293	19,763,479	7,110,186	36.0%
Total Operating Expenses	**1,818,331**	**2,953,574**	**1,135,243**	**38.4%**	**17,932,782**	**27,049,314**	**9,116,532**	**33.7%**	**24,632,328**	**38,176,427**	**13,544,099**	**35.5%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	56,990,000	22,543,779	34,446,221
FY2023 Operating Budget[2]	11,127,113	6,699,546	4,427,567
FY2024 Operating Budget	30,002,899	17,932,782	12,070,117
FY2025 Operating Budget			
Ending Funding Balance	**1,879,988**	**52,823,892**	
Add: Prior year unspent Operating Budget	**4,427,567**		
Total Available Funding	**6,307,555**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding

Note: Report includes applicable transactions for GASB 96, Subscription.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of May 31, 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	780,255	183,006
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,674
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,088,877	3,987,775
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$43,949,325**	**$57,850,675**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$43,949,325**	**$17,750,675**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

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

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of May 31, 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	23,648,399	11,552,595	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,845,565	26,538,965	-
Total	**160,315,719**	**122,585,524**	**84,493,965**	**38,091,560**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	418,000	382,000	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013	HHI & DHCS
Infrastructure Projects	5,832,314	5,321,731	510,583	HHI
Capital Projects	98,247,369	73,300,000	24,947,369	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	-	10,184,530	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524**[1]	**$84,493,965**	**$38,091,560**	

Notes:
[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes as of May 31, 2024

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-24
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP	2023-24
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter	2023-24
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce iView to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract	2023-24
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards	2023-24
September	One Care	Office of Compliance - Professional Fees - CPE Audit	Office of Compliance - Professional Fees - Blue Peak Services	$20,000	To reallocate funds from Professional Fees – CPE Audit to Professional Fees – Blue Peak Services to provide funding for Blue Peak Services	2023-24
September	Medi-Cal	Customer Service - Member Communication – Maintenance of Business, Ad-Hoc/New Projects	Provider Data Mgmt. Svcs – Purchased Services	$60,000	To reallocate funds from Customer Service – Member Communication Maintenance of Business and Ad-Hoc/New Projects to Provider Data Management Services – Purchased Services to provide funding for provider directory PDF Remediation services	2023-24
September	Medi-Cal	Facilities - Audio Visual Enhancements	Facilities - CalOptima Health New Vehicle	$13,135	To reallocate funds from Facilities – Audio Visual Enhancements to Facilities – CalOptima Health New Vehicle for a new company vehicle	2023-24
September	Medi-Cal	Medical Management – Other Operating Expenses – Training & Seminar	Behavioral Health Integration – Professional Fees	$16,000	To reallocate funds from Medical Management – Other Operating Expenses – Training & Seminar to Behavioral Health Integration – Professional Fees to provide funding for Autism Spectrum Therapies	2023-24
September	Medi-Cal	Population Health Management – Purchased Services – Capacity Building Vendor	Population Health Management – Purchased Services – Capacity Building	$150,000	To repurpose funds from Purchased Services – Capacity Building Vendor to support the new Medi-Cal benefit, including incentives for contracting with CCN and delegated Health Networks, doula training, and technical assistance	2023-24
September	Medi-Cal	IS – Enterprise Data & Sys Integration – Professional Fees	Enterprise Project Management Office – Professional Fees	$75,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
September	Medi-Cal	IS – Application Development – Maintenance HW/SW	Enterprise Project Management Office – Professional Fees	$55,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
October	Medi-Cal	DTS Capital: Migrate Data Warehouse / Analytics to the Cloud	DTS Capital: Enterprise Data Quality Enhancement	$140,000	To reallocate funds from AppDev – Migrate Data Warehouse Analytics to AppDev – Enterprise Data Quality Enhancement to help with Collibra Data Governance invoice	2023-24
October	Medi-Cal	Medi-Cal/Claim - Other Operating Expenses - Food Service Supply	Medi-Cal/Claim - Other Operating Expenses - Travel	$16,000	To reallocate funds from Medi-Cal/Claim – Food Service Supply to Medi-Cal/Claim – Travel to provide funding for Center for Care Innovations	2023-24
October	Medi-Cal	Is – Infrastructure – Other Operating Expenses – Maintenance HW/SW	Provider Data Management Services – Purchased Services	$54,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
October	One Care	IS – Application Management – Maintenance HW/SW	Provider Data Management Services - Purchased Services	$24,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
November	Medi-Cal	IS - Application Management - Maintenance HW/SW	Medical Management - Professional Fees	$100,000	To reallocate funds from IS-Applications Management - Maintenance HW/SW IBM WebSphere to Medical Management - Professional Fees to fund a consulting project	2023-24
November	Medi-Cal	Executive Office - Professional Fees	Executive Office - Other Operating Expenses - Professional Dues	$28,000	To reallocate funds from Professional Fees to Professional Dues to pay for CCI Membership	2023-24
November	Medi-Cal	Infrastructure - Misc. HW/SW Technology Equipment (New Hire Equip)	Infrastructure - HW/SW Maintenance (Palo Alto Firewall)	$84,000	To reallocate funds from Infrastructure Misc. HW/SW Technology Equipment (New Hire Equipment) to HW/SW Maintenance (Palo Alto Firewall) to help with shortage of funds due to contract is co-termed	2023-24
December	Medi-Cal	505 Building - Repair & Maintenance	505 Building - Purchased Services	$228,798	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	500 Building - Repair & Maintenance	500 Building - Purchased Services	$192,120	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - F5 Network	$47,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - Calabrio	$29,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Application Mgmt. - Maintenance HW/SW (IBM WebSphere)	Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau)	$249,990	To reallocate funds from Application Mgmt. - Maintenance HW/SW (IBM WebSphere) to Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau) to help with Tableau invoice.	2023-24
December	Medi-Cal	Facilities - Comp supply/Minor Equipment	Facilities - R&M - Building	$100,000	To reallocate fund from Comp Supply/Minor Equipment to R&M - Building to address unanticipated repair costs	2023-24
December	Medi-Cal	Professional Fees - Altruista	Purchased Services - MCG	$40,000	To reallocate funds from Professional Fees - Altruista to Purchased Services - MCG to help with CMS requirement to add a link in CalOptima Health's website for Medicare members	2023-24
January	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Equipment	Delegation Oversight - Professional Fees	$96,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment to Delegation Oversight - Professional Fees to provide funding for a consultant services	2023-24
January	Medi-Cal	IS - Application Development - Professional Fees	Operations Management - Professional Fees	$150,000	To reallocate funds from Application Development – Professional Fees to Operations Management - Professional Fees to help with additional services	2023-24
January	Medi-Cal	Integrated Provider Data Management System	New Ticketing Tool for CalOptima Staff	$50,000	To reallocate funds from Integrated Provider Data Management System to New Ticketing Tool for CalOptima Staff due to shortfall of funds in Phase II	2023-24
February	Medi-Cal	IS - Infrastructure - New Hire Equipment	Executive Office - Public Activities	$17,000	To reallocate funds from Infrastructure - New Hire Equipment to Executive Office - Public Activities to provide funding to support events	2023-24
February	One Care	Customer Service - Printing and Postage - Communications	Cultural & Linguistics - Purchased Services	$50,000	To reallocate funds from Customer Service - Printing and Postage to Cultural & Linguistics - Purchased Services to supplement the anticipated gap	2023-24
February	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Grievance & Appeals - Purchased Services	$20,000	To reallocate funds from Enterprise Data & Sys Integration - Professional Fees to Grievance & Appeals - Purchased Services to provide additional funding for data scanning and storage	2023-24
February	Medi-Cal	IS-Infrastructure - Other Operating Expenses - Misc HW/SW Equipment Supplies	Provider Data Management Services - Purchased Services	$71,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment Supplies to Provider Data Management Services - Professional Fees to provide funding for provider directory PDF Remediation Services	2023-24
February	One Care	Communications - Professional Fees	Communications - Printing and Postage - Member Communication	$150,000	To reallocate funds from Communications - Professional Fees to Member Communication to provide funding needed for OneCare marketing and advertising program	2023-24
February	Medi-Cal	Infrastructure - New Hire Equipment	IS - Infrastructure - Cisco	$18,000	To reallocate funds from Infrastructure - New Hire Equipment to Infrastructure - Cisco due to shortfall of funds	2023-24
March	One Care	Quality Analytics - Professional Fees	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	One Care	Quality Analytics - Purchased Services - Stars Initiatives	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - R&M - Building	$100,000	To reallocate funds from Facilities - Office Supplies to R&M to provide funding needed for building maintenance	2023-24
March	Medi-Cal	IS - Infrastructure - Technology Equipment	IS - Infrastructure - UGovernIT	$40,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Telco Misc HW/SW	IS - Infrastructure - Palo Alto Firewall	$118,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - App Development - Provider Virtual Agent Support	IS - App Development - Migrate Website Content Management System to the Cloud	$67,100	To reallocate funds from Provider Virtual Agent Support to Migrate Website Content Management System to the Cloud due to shortfall of funds	2023-24
March	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Executive Office - Professional Fees	$28,000	To reallocate funds from IS - Enterprise & System Integration - Professional Fees to Executive Office - Professional Fees to provide funding for communications consultant	2023-24
March	Medi-Cal	IS - Cyber Security - Data Loss Prevention Suite	IS - Cyber Security - Tipping Point Intrusion Preon System	$32,000	To reallocate funds from IS - Cyber Security - Data Loss Prevention Suite to IS - Cyber Security - Tipping Point Intrusion Prevention System due to shortage of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Computer Equipment Refresh	IS - App Development - Secure Auth Web Access Management	$220,000	To reallocate funds from IS - Infrastructure - Computer Equipment Refresh to IS - App Development - Secure Auth Web Access Management due to shortage of funds	2023-24
April	Medi-Cal	IS - Applications Management - Other Operating Expenses - Maint HW/SW - Vendor Selection TBD	IS - Applications Management - Other Operating Expenses - Maint HW/SW - MCG Integrated Criteria	$20,000	To reallocate funds from IS - Applications Management - Maint HW/SW - Vendor Selection TBD to Maint HW/SW - MCG Integrated Criteria due to shortage of funds	2023-24
April	Medi-Cal	Communications - Printing and Postage - Member Communications	Communications- Purchased Services - Advertising	$25,000	To reallocate funds from Communications - Printing and Postage - Member Communications to Purchased Services - Advertising to provide additional funding for the remainder of the fiscal year	2023-24
April	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Purchased Services - Advertising	$34,000	To reallocate funds from PACE Marketing - Printing and Postage - Member Communication to Purchased Services - Advertising and Public Activities to provide additional funding for the remainder of the fiscal year	2023-24
April	OneCare	Sales & Marketing - Purchased Services - FMO and or Broker Agency Commissions and Override Fees	IS - Applications Management - Other Operating Expenses - HealthEdge Burgess Group	$150,000	To reallocate funds from the Sales & Marketing - FMO and or Broker Agency Commissions and Override Fees to IS - Applications Management - HealthEdge Burgess Group due to shortage of funds	2023-24
April	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Technology Equipment	IS - Application Development - Other Operating Expenses - Ceridian	$161,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Technology Equipment to IS - Application Development - Ceridian due to shortage of funds	2023-24
May	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Grievance & Appeals - Professional Fees	$82,000	To reallocate funds from IS - Enterprise Data & System Integration - Professional Fees to Grievance & Appeals - Professional Fees to provide funding needed for consulting service.	2023-24
May	Medi-Cal	Equity and Community Health - Printing and Postage	Equity and Community Health - Purchased Services	$130,000	To reallocate funds from Equity and Community Health - Printing and Postage to Purchased Services to provide funding for a new training module.	2023-24
May	OneCare	Customer Service - Printing and Postage - Communications	Cultural & Linguistic Services - Purchased Services - Telephonic Interpretation	$60,000	To reallocate funds Customer Service - Communications to Cultural & Linguistic Services - Telephonic Interpretation to provide additional funding needed for the remainder of the fiscal year.	2023-24
May	Medi-Cal	IS - Application Development - Other Operating Expenses - Maintenance HW/SW	Operations Management - Professional Fees - DTS Consulting Services	$230,000	To reallocate funds from IS - Application Development - Maintenance HW/SW to Operation Management - DTS Consulting Services due to shortfall of funds.	2023-24
May	OneCare	Communications - Printing and Postage - Member Communications	Communications - Professional Fees	$150,000	To reallocate funds from Communications - Member Communication to Professional Fees to provide additional funding needed for the remainder of the year.	2023-24
May	Medi-Cal	IS - Infrastructure - Other Operating Expenses - New Hire Equipment	IS - Application Development - Other Operating Expenses - Human Resource Applicant Tracking System	$92,000	To reallocate funds from IS - Infrastructure - New Hire Equipment to IS - Application Development - Human Resource Applicant Tracking System due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Professional Fees - IT Service Management	IS - Infrastructure - Other Operating Expenses - HDI Training & Seminars	$23,000	To reallocate funds from IS - Infrastructure - IT Service Management to IS - Infrastructure - HDI Training & Seminars due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Professional Fees - IT Service Management	IS - Infrastructure - Other Operating Expenses - Azure Training & Seminars	$25,000	To reallocate funds from IS - Infrastructure - IT Service Management to IS - Infrastructure - Azure Training & Seminars due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Subscriptions	Customer Service - Purchased Services	$100,000	To reallocate funds from ITS - Infrastructure - Subscriptions to Customer Service - Purchased Services to provide additional funding to pay for Centauri invoices for the remainder of the fiscal year.	2023-24

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

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Financial Summary

Preliminary Unaudited Financials

June 30, 2024

Board of Directors Meeting

August 1, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights: June 2024

June 2024					July 2023 - June 2024			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
919,052	810,038	109,014	13.5%	Member Months	11,408,577	10,793,544	615,033	5.7%
930,989,668	307,264,809	623,724,859	203.0%	Revenues	5,368,374,569	4,014,893,010	1,353,481,559	33.7%
450,692,497	294,053,440	(156,639,057)	(53.3%)	Medical Expenses	4,501,293,527	3,785,719,951	(715,573,576)	(18.9%)
24,215,256	22,436,201	(1,779,055)	(7.9%)	Administrative Expenses	230,780,376	259,121,805	28,341,429	10.9%
456,081,916	**(9,224,832)**	**465,306,748**	**5,044.1%**	**Operating Margin**	**636,300,666**	**(29,948,746)**	**666,249,412**	**2,224.6%**
				Non-Operating Income (Loss)				
16,275,256	2,083,370	14,191,886	681.2%	Net Investment Income/Expense	175,868,046	25,000,000	150,868,046	603.5%
(38,589)	(89,374)	50,785	56.8%	Net Rental Income/Expense	(207,814)	(902,553)	694,739	77.0%
(252,577)	-	(252,577)	(100.0%)	Net MCO Tax	551,456	-	551,456	100.0%
(2,539,594)	(1,003,223)	(1,536,371)	(153.1%)	Grant Expense	(32,025,455)	(32,038,636)	13,182	0.0%
-	-	-	0.0%	Net QAF/IGT	0	-	0	100.0%
15	-	15	100.0%	Other Income/Expense	(829,898)	-	(829,898)	(100.0%)
13,444,511	**990,773**	**12,453,738**	**1,257.0%**	**Total Non-Operating Income (Loss)**	**143,356,334**	**(7,941,189)**	**151,297,524**	**1,905.2%**
469,526,427	**(8,234,059)**	**477,760,486**	**5,802.2%**	**Change in Net Assets**	**779,657,000**	**(37,889,935)**	**817,546,936**	**2,157.7%**
48.4%	*95.7%*	*(47.3%)*		*Medical Loss Ratio*	*83.8%*	*94.3%*	*(10.4%)*	
2.6%	*7.3%*	*4.7%*		*Administrative Loss Ratio*	*4.3%*	*6.5%*	*2.2%*	
49.0%	*(3.0%)*	*52.0%*		*Operating Margin Ratio*	*11.9%*	*(0.7%)*	*12.6%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
133.2%	*95.7%*	*37.5%*		**Adjusted MLR*	*94.4%*	*94.3%*	*0.2%*	
7.2%	*7.3%*	*0.1%*		**Adjusted ALR*	*5.2%*	*6.5%*	*1.2%*	

*Adjusted MLR and ALR excludes Hospital Directed Payments, Prior Year risk corridors and rate adjustments

Financial Highlights Notes: June 2024

- Major Year-End Adjustments
  - $647.0 million of Calendar Years (CY) 2021 to 2023 COVID-19 risk corridor release of accrued liabilities
  - $107.5 million of estimated expenses relating to CY 2024 Community Reinvestment and Quality Achievement Requirement per the Department of Health Care Services (DHCS) 2024 contract
  - $54.3 million revenue reduction relating to CY 2023 population acuity adjustment from DHCS
  - $11.1 million revenue reduction from CY 2024 Unsatisfactory Immigration Status (UIS) risk corridor estimates

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) June 2024: $469.5 million, favorable to budget $477.8 million or 5,802.2% due to CY 2021-2023 COVID-19 risk corridor and offset by CY 2024 Community Reinvestment and CY 2023 rate adjustment
  - Year To Date (YTD) July 2023 – June 2024: $779.7 million, favorable to budget $817.5 million or 2,157.7% due to net favorable enrollment and rates, COVID-19 risk corridor, and net investment income offset by Community Reinvestment

- Enrollment
  - MTD: 919,052 members, favorable to budget 109,014 or 13.5%
  - YTD: 11,408,577 member months, favorable to budget 615,033 or 5.7%

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FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $931.0 million, favorable to budget $623.7 million or 203.0% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due primarily to the release of CY 2021-2023 COVID-19 risk corridor
  - YTD: $5,368.4 million, favorable to budget $1,353.5 million or 33.7%
    - Driven primarily by COVID-19 risk corridor, Hospital Directed Payments (DP), CalAIM Incentive Payment Program (IPP), HHIP, favorable membership mix and capitation rates from DHCS

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $450.7million, unfavorable to budget $156.6 million or 53.3%
    - Other Medical Expenses unfavorable variance of $107.4 million due to CY 2024 Community Reinvestment and Quality Achievement accrual
    - Net unfavorable variance from all other categories of $50 million driven primarily by Community Support (CS) expenses and Post-Public Health Emergency (PHE) supplemental payments
  - YTD: $4,501.3 million, unfavorable to budget $715.6 million or 18.9%
    - Driven primarily by Hospital DP, CS services, Community Reinvestment, post-PHE payments and HHIP

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FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $24.2 million, unfavorable to budget $1.8 million or 7.9% due to net change in Pension and Other Post-Employment Benefits (OPEB) liability
  - YTD: $230.8 million, favorable to budget $28.3 million or 10.9%

- Non-Operating Income (Loss)
  - MTD: $13.4 million, favorable to budget $12.5 million or 1,257.0% due primarily to net investment income
  - YTD: $143.4 million, favorable to budget $151.3 million or 1,905.2% due primarily to net investment income

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FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 48.4% (133.2% excluding DP, Prior Year (PY) risk corridors and rate adjustments), Budget 95.7%
  - YTD: Actual 83.8% (94.4% excluding DP, PY risk corridors and rate adjustments), Budget 94.3%

- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.6% (7.2% excluding DP, PY risk corridors and rate adjustments), Budget 7.3%
  - YTD: Actual 4.3% (5.2% excluding DP, PY risk corridors and rate adjustments), Budget 6.5%

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

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FY 2023-24: Key Financial Ratios

- Balance Sheet Ratios
  - Current ratio*: 1.7
  - Board Designated Reserve level: 2.82
  - Statutory Designated Reserve level: 1.03
  - Net-position: $2.4 billion, including required Tangible Net Equity (TNE) of $127.5 million

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

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Enrollment Summary: June 2024

June 2024					July 2023 - June 2024			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
139,602	131,452	8,150	6.2%	SPD	1,694,221	1,644,002	50,219	3.1%
275,019	266,863	8,156	3.1%	TANF Child	3,469,516	3,511,078	(41,562)	(1.2%)
134,360	123,760	10,600	8.6%	TANF Adult	1,669,412	1,548,172	121,240	7.8%
2,598	3,109	(511)	(16.4%)	LTC	33,016	37,397	(4,381)	(11.7%)
340,086	256,352	83,734	32.7%	MCE	4,200,004	3,703,532	496,472	13.4%
9,638	10,607	(969)	(9.1%)	WCM	127,071	131,742	(4,671)	(3.5%)
901,303	**792,143**	**109,160**	**13.8%**	**Medi-Cal Total**	**11,193,240**	**10,575,923**	**617,317**	**5.8%**
17,253	**17,387**	**(134)**	**(0.8%)**	**OneCare**	**209,851**	**211,878**	**(2,027)**	**(1.0%)**
496	**508**	**(12)**	**(2.4%)**	**PACE**	**5,486**	**5,743**	**(257)**	**(4.5%)**
483	**568**	**(85)**	**(15.0%)**	**MSSP**	**5,893**	**6,816**	**(923)**	**(13.5%)**
919,052	**810,038**	**109,014**	**13.5%**	**CalOptima Health Total**	**11,408,577**	**10,793,544**	**615,033**	**5.7%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: June 2024 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	561,217	340,086	901,303	17,253		496	483	919,052
REVENUES								
Capitation Revenue	$ 520,585,696	$ 373,045,415	$ 893,631,110	$ 32,857,486	$ -	$ 4,285,677	$ 215,394	$ 930,989,668
Total Operating Revenue	**520,585,696**	**373,045,415**	**893,631,110**	**32,857,486**	**-**	**4,285,677**	**215,394**	**930,989,668**
MEDICAL EXPENSES								
Provider Capitation	59,729,003	47,896,093	107,625,096	14,821,957				122,447,054
Claims	71,831,239	51,951,374	123,782,613	6,893,281	(64,552)	1,856,475		132,467,817
MLTSS	43,400,853	5,785,376	49,186,229		(8,642)	5,927	30,816	49,214,331
Prescription Drugs	-			8,097,717		578,360		8,676,077
Case Mgmt & Other Medical	84,431,237	50,842,392	135,273,629	1,446,605	(214,318)	1,236,485	144,817	137,887,219
Total Medical Expenses	**259,392,332**	**156,475,235**	**415,867,568**	**31,259,561**	**(287,512)**	**3,677,247**	**175,633**	**450,692,497**
Medical Loss Ratio	*49.8%*	*41.9%*	*46.5%*	*95.1%*	*0.0%*	*85.8%*	*81.5%*	*48.4%*
GROSS MARGIN	**261,193,363**	**216,570,179**	**477,763,543**	**1,597,925**	**287,512**	**608,431**	**39,762**	**480,297,172**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			13,521,932	985,455		141,933	95,867	14,745,187
Non-Salary Operating Expenses			4,000,262	730,688		(21,579)	1,333	4,710,704
Depreciation & Amortization			811,260			939		812,199
Other Operating Expenses			3,315,190	115,911		15,321	13,220	3,459,641
Indirect Cost Allocation, Occupancy			(168,720)	644,546		10,466	1,234	487,526
Total Administrative Expenses			**21,479,923**	**2,476,599**	**-**	**147,079**	**111,654**	**24,215,256**
Administrative Loss Ratio			*2.4%*	*7.5%*	*0.0%*	*3.4%*	*51.8%*	*2.6%*
Operating Income/(Loss)			**456,283,620**	**(878,674)**	**287,512**	**461,351**	**(71,892)**	**456,081,916**
Investments and Other Non-Operating			(252,562)					13,444,511
CHANGE IN NET ASSETS			**$ 456,031,058**	**$ (878,674)**	**$ 287,512**	**$ 461,351**	**$ (71,892)**	**$ 469,526,427**
BUDGETED CHANGE IN NET ASSETS			(6,769,199)	(2,496,046)	-	110,368	(69,955)	(8,234,059)
Variance to Budget - Fav/(Unfav)			$ 462,800,257	$ 1,617,372	$ 287,512	$ 350,983	$ (1,937)	$ 477,760,486

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Consolidated Revenue & Expenses: June 2024 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	6,993,236	4,200,004	11,193,240	209,851		5,486	5,893	11,408,577
REVENUES								
Capitation Revenue	$ 2,890,266,540	$ 2,020,584,630	$4,910,851,169	$ 408,847,800	$ (1,367,196)	$ 47,473,870	$ 2,568,926	$ 5,368,374,569
Total Operating Revenue	**2,890,266,540**	**2,020,584,630**	**4,910,851,169**	**408,847,800**	**(1,367,196)**	**47,473,870**	**2,568,926**	**5,368,374,569**
MEDICAL EXPENSES								
Provider Capitation	715,475,999	570,254,178	1,285,730,177	177,859,584				1,463,589,761
Claims	917,126,186	593,649,559	1,510,775,745	78,067,735	53,079	19,581,500		1,608,478,059
MLTSS	515,520,874	67,726,710	583,247,583	-	(27,145)	(4,176)	319,143	583,535,404
Prescription Drugs	(11,660)		(11,660)	97,891,784	(1,822,942)	6,150,537		102,207,719
Case Mgmt & Other Medical	435,892,640	274,523,744	710,416,384	17,425,490	(161,910)	14,009,516	1,793,104	743,482,584
Total Medical Expenses	**2,584,004,038**	**1,506,154,191**	**4,090,158,229**	**371,244,593**	**(1,958,918)**	**39,737,377**	**2,112,246**	**4,501,293,527**
Medical Loss Ratio	*89.4%*	*74.5%*	*83.3%*	*90.8%*	*143.3%*	*83.7%*	*82.2%*	*83.8%*
GROSS MARGIN	**306,262,502**	**514,430,439**	**820,692,940**	**37,603,207**	**591,722**	**7,736,493**	**456,680**	**867,081,042**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			134,029,759	12,015,719	(0)	1,933,018	1,117,754	149,096,250
Non-Salary Operating Expenses			34,195,498	4,552,094	(4,364)	497,736	16,048	39,257,012
Depreciation & Amortization			7,995,324			13,304		8,008,628
Other Operating Expenses			28,943,929	802,881		108,416	76,530	29,931,756
Indirect Cost Allocation, Occupancy			(6,919,497)	11,160,398		175,704	70,124	4,486,730
Total Administrative Expenses			**198,245,014**	**28,531,092**	**(4,364)**	**2,728,177**	**1,280,457**	**230,780,376**
Administrative Loss Ratio			*4.0%*	*7.0%*	*0.3%*	*5.7%*	*49.8%*	*4.3%*
Operating Income/(Loss)			**622,447,927**	**9,072,115**	**596,086**	**5,008,316**	**(823,777)**	**636,300,666**
Investments and Other Non-Operating			(278,442)					143,356,334
CHANGE IN NET ASSETS			**$ 622,169,484**	**$ 9,072,115**	**$ 596,086**	**$ 5,008,316**	**$ (823,777)**	**$ 779,657,000**
BUDGETED CHANGE IN NET ASSETS			(685,663)	(28,481,719)	-	98,983	(880,347)	(37,889,935)
Variance to Budget - Fav/(Unfav)			$ 622,855,147	$ 37,553,834	$ 596,086	$ 4,909,333	$ 56,570	$ 817,546,936

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Balance Sheet: As of June 2024

ASSETS	
Current Assets	
Operating Cash	$527,999,317
Short-term Investments	1,777,895,940
Receivables & Other Current Assets	561,817,735
Total Current Assets	**2,867,712,992**
Capital Assets	
Capital Assets	178,245,738
Less Accumulated Depreciation	(81,684,930)
Capital Assets, Net of Depreciation	96,560,808
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,005,885,164
Statutory Designated Reserves	131,878,274
Total Other Assets	**1,138,063,438**
TOTAL ASSETS	**4,102,337,238**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,178,236,245**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$172,319,606
Medical Claims Liability	1,151,144,125
Capitation and Withholds	167,506,321
Other Current Liabilities	148,649,563
Total Current Liabilities	**1,639,619,615**
Other Liabilities	
GASB 96 Subscription Liabilities	16,955,572
Postemployment Health Care Plan	17,370,000
Net Pension Liabilities	45,981,359
Total Other Liabilities	**80,306,931**
TOTAL LIABILITIES	**1,719,926,546**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	127,508,151
Funds in Excess of TNE	2,322,155,103
TOTAL NET POSITION	**2,449,663,254**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,178,236,245**

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Board Designated Reserve and TNE Analysis: As of June 2024

Board Designated Reserves

	Investment Account Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Payden & Rygel Tier One	503,164,581				
	MetLife Tier One	502,720,583				
Board Designated Reserves		1,005,885,164	891,066,767	1,069,280,121	114,818,397	(63,394,957)
	Current Reserve Level	*2.82*	*2.50*	*3.00*		

Statutory Designated Reserves

	Investment Account Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Payden & Rygel Tier Two	66,117,950				
	MetLife Tier Two	65,760,324				
Statutory Designated Reserves		131,878,274	127,508,151	140,258,966	4,370,123	(8,380,692)
	Current Reserve Level	*1.03*	*1.00*	*1.10*		

- On May 2, 2024, the Board approved modifications to GA.3001: Statutory and Board-Designated Reserve Funds effective June 2024.

Spending Plan: As of June 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 6/30/2024	**$2,449.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,005.9**			**41.1%**
	Statutory Designated Reserve[1]	**$131.9**			**5.4%**
	Capital Assets, net of Depreciation[2]	**$96.6**			**3.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.7	$61.7	44.0	0.7%
	Housing and Homelessness Incentive Program[4]	22.2	87.4	65.2	0.9%
	Intergovernmental Transfers (IGT)	59.9	111.7	51.8	2.4%
	Digital Transformation and Workplace Modernization[5]	50.6	100.0	49.4	2.1%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.2	2.0	1.8	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.7	4.7	3.0	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	137.0	153.5	16.5	5.6%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Gra	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located i	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	47.6	50.0	2.4	1.9%
	Distribution Event- Naloxone Grant	2.4	15.0	12.6	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	15.1	107.5	92.4	0.6%
	CalOptima Health Community Reinvestment Program	37.1	38.0	0.9	1.5%
	Outreach Strategy for newly eligible Adult Expansion members	4.4	5.0	0.6	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.0%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	526.2	526.2	0.0	21.5%
	Subtotal:	**$1,027.7**	**$1,417.8**	**$390.1**	**42.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$187.6**	**$526.2**		**7.7%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 113 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[5] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

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Homeless Health Initiative and Allocated Funds: As of June 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	791,124	172,137
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,675
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,089,152	3,987,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$43,960,469**	**$57,839,532**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$43,960,469**	**$17,739,532**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

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

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Housing and Homelessness Incentive Program As of June 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	24,445,914	10,755,080	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,167,297	22,217,233	-
Total	**160,315,719**	**122,585,524**	**89,613,211**	**32,972,314**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	424,650	375,350	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	797,515	9,387,015	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$89,613,211**	**$32,972,314**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

June 30, 2024

Preliminary Reports as of July 18, 2024

Final fiscal year report is subject to change following financial audit

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CalOptima Health - Consolidated
Financial Highlights
For the Twelve Months Ending June 30, 2024

June 2024					July 2023 - June 2024			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
919,052	810,038	109,014	13.5%	Member Months	11,408,577	10,793,544	615,033	5.7%
930,989,668	307,264,809	623,724,859	203.0%	Revenues	5,368,374,569	4,014,893,010	1,353,481,559	33.7%
450,692,497	294,053,440	(156,639,057)	(53.3%)	Medical Expenses	4,501,293,527	3,785,719,951	(715,573,576)	(18.9%)
24,215,256	22,436,201	(1,779,055)	(7.9%)	Administrative Expenses	230,780,376	259,121,805	28,341,429	10.9%
456,081,916	**(9,224,832)**	**465,306,748**	**5,044.1%**	**Operating Margin**	**636,300,666**	**(29,948,746)**	**666,249,412**	**2,224.6%**
				Non-Operating Income (Loss)				
16,275,256	2,083,370	14,191,886	681.2%	Net Investment Income/Expense	175,868,046	25,000,000	150,868,046	603.5%
(38,589)	(89,374)	50,785	56.8%	Net Rental Income/Expense	(207,814)	(902,553)	694,739	77.0%
(252,577)	-	(252,577)	(100.0%)	Net MCO Tax	551,456	-	551,456	100.0%
(2,539,594)	(1,003,223)	(1,536,371)	(153.1%)	Grant Expense	(32,025,455)	(32,038,636)	13,182	0.0%
15	-	15	100.0%	Other Income/Expense	(829,898)	-	(829,898)	(100.0%)
13,444,511	**990,773**	**12,453,738**	**1,257.0%**	**Total Non-Operating Income (Loss)**	**143,356,334**	**(7,941,189)**	**151,297,524**	**1,905.2%**
469,526,427	**(8,234,059)**	**477,760,486**	**5,802.2%**	**Change in Net Assets**	**779,657,000**	**(37,889,935)**	**817,546,936**	**2,157.7%**
48.4%	*95.7%*	*(47.3%)*		*Medical Loss Ratio*	*83.8%*	*94.3%*	*(10.4%)*	
2.6%	*7.3%*	*4.7%*		*Administrative Loss Ratio*	*4.3%*	*6.5%*	*2.2%*	
49.0%	*(3.0%)*	*52.0%*		*Operating Margin Ratio*	*11.9%*	*(0.7%)*	*12.6%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
133.2%	*95.7%*	*37.5%*		**Adjusted MLR*	*94.4%*	*94.3%*	*0.2%*	
7.2%	*7.3%*	*0.1%*		**Adjusted ALR*	*5.2%*	*6.5%*	*1.2%*	

*Adjusted MLR and ALR excludes Hospital Directed Payments, Prior Year risk corridors and rate adjustments

Preliminary

CalOptima Health - Consolidated
Full Time Employee Data
For the Twelve Months Ending June 30, 2024

Total FTE's MTD	Actual	Budget	Fav/Unfav
Medi-Cal	1,274	1,341	67
OneCare	169	194	25
PACE	106	115	9
MSSP	20	24	4
Total	1,569	1,673	104

Total FTE's YTD	Actual	Budget	Fav/Unfav
Medi-Cal	15,132	16,162	1,029
OneCare	2,138	2,347	209
PACE	1,261	1,301	40
MSSP	234	282	48
Total	18,766	20,091	1,325

MM per FTE MTD	Actual	Budget	Fav/Unfav
Medi-Cal	707	591	(116)
OneCare	102	90	(12)
PACE	5	4	(1)
MSSP	25	24	(1)
Consolidated	586	484	(102)

MM per FTE YTD	Actual	Budget	Fav/Unfav
Medi-Cal	740	654	(86)
OneCare	98	90	(8)
PACE	4	4	0
MSSP	25	24	(1)
Consolidated	608	537	(71)

Open FTE	Total	Medical	Admin
Medi-Cal	78	31	47
OneCare	10	6	4
PACE	2	1	1
MSSP	2	1	1
Total	92	39	53

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending June 30, 2024

	Actual		Budget		Variance	
MEMBER MONTHS		919,052		810,038		109,014
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$893,631,110	$991.49	$270,715,011	$341.75	$622,916,099	$649.74
OneCare	32,857,486	1,904.45	31,907,315	1,835.12	950,171	69.33
OneCare Connect	-		-		-	-
PACE	4,285,677	8,640.48	4,388,973	8,639.71	(103,296)	0.77
MSSP	215,394	445.95	253,510	446.32	(38,116)	(0.37)
Total Operating Revenue	930,989,668	1,012.99	307,264,809	379.32	623,724,859	633.67
MEDICAL EXPENSES						
Medi-Cal	415,867,568	461.41	258,337,238	326.12	(157,530,330)	(135.29)
OneCare	31,259,561	1,811.83	31,460,881	1,809.45	201,320	(2.38)
OneCare Connect	(287,512)				287,512	-
PACE	3,677,247	7,413.80	4,036,632	7,946.13	359,385	532.33
MSSP	175,633	363.63	218,689	385.02	43,056	21.39
Total Medical Expenses	450,692,497	490.39	294,053,440	363.01	(156,639,057)	(127.38)
GROSS MARGIN	480,297,172	522.60	13,211,369	16.31	467,085,803	506.29
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	14,745,187	16.04	12,042,899	14.87	(2,702,288)	(1.17)
Professional Fees	1,620,355	1.76	1,376,526	1.70	(243,829)	(0.06)
Purchased Services	2,518,281	2.74	3,289,225	4.06	770,944	1.32
Printing & Postage	572,067	0.62	833,101	1.03	261,034	0.41
Depreciation & Amortization	812,199	0.88	400,900	0.49	(411,299)	(0.39)
Other Expenses	3,459,641	3.76	4,048,661	5.00	589,020	1.24
Indirect Cost Allocation, Occupancy	487,526	0.53	444,889	0.55	(42,637)	0.02
Total Administrative Expenses	24,215,256	26.35	22,436,201	27.70	(1,779,055)	1.35
NET INCOME (LOSS) FROM OPERATIONS	456,081,916	496.25	(9,224,832)	(11.39)	465,306,748	507.64
INVESTMENT INCOME						
Interest Income	14,757,571	16.06	2,083,370	2.57	12,674,201	13.49
Realized Gain/(Loss) on Investments	485,058	0.53	-	-	485,058	0.53
Unrealized Gain/(Loss) on Investments	1,032,627	1.12	-	-	1,032,627	1.12
Total Investment Income	16,275,256	17.71	2,083,370	2.57	14,191,886	15.14
NET RENTAL INCOME/EXPENSE	(38,589)	(0.04)	(89,374)	(0.11)	50,785	0.07
NET MCO TAX	(252,577)	(0.27)	-	-	(252,577)	(0.27)
GRANT EXPENSE	(2,539,594)	(2.76)	(1,003,223)	(1.24)	(1,536,371)	(1.52)
OTHER INCOME/EXPENSE	15	-	-	-	15	-
CHANGE IN NET ASSETS	**469,526,427**	**510.88**	**(8,234,059)**	**(10.17)**	**477,760,486**	**521.05**
MEDICAL LOSS RATIO	**48.4%**		**95.7%**		**(47.3%)**	
ADMINISTRATIVE LOSS RATIO	**2.6%**		**7.3%**		**4.7%**	

Preliminary

CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

	Actual		Budget		Variance	
MEMBER MONTHS		11,408,577		10,793,544		615,033
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
REVENUE						
Medi-Cal	$4,910,851,169	$438.73	$3,578,731,343	$338.38	$1,332,119,826	$100.35
OneCare	408,847,800	1,948.28	383,711,815	1,811.00	25,135,985	137.28
OneCare Connect	(1,367,196)		-		(1,367,196)	0.00
PACE	47,473,870	8,653.64	49,407,644	8,603.11	(1,933,774)	50.53
MSSP	2,568,926	435.93	3,042,208	446.33	(473,282)	(10.40)
Total Operating Revenue	5,368,374,569	470.56	4,014,893,010	371.97	1,353,481,559	98.59
MEDICAL EXPENSES						
Medi-Cal	4,090,158,229	365.41	3,357,252,714	317.44	(732,905,515)	(47.97)
OneCare	371,244,593	1,769.09	379,250,411	1,789.95	8,005,818	20.86
OneCare Connect	(1,958,918)				1,958,918	0.00
PACE	39,737,377	7,243.42	46,597,646	8,113.82	6,860,269	870.40
MSSP	2,112,246	358.43	2,619,180	384.27	506,934	25.84
Total Medical Expenses	4,501,293,527	394.55	3,785,719,951	350.74	(715,573,576)	(43.81)
GROSS MARGIN	867,081,042	76.01	229,173,059	21.23	637,907,983	54.78
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	149,096,250	13.07	150,830,106	13.97	1,733,856	0.90
Professional Fees	10,609,405	0.93	14,052,680	1.30	3,443,275	0.37
Purchased Services	22,407,026	1.96	30,826,055	2.86	8,419,029	0.90
Printing & Postage	6,240,580	0.55	7,582,980	0.70	1,342,400	0.15
Depreciation & Amortization	8,008,628	0.70	4,810,800	0.45	(3,197,828)	(0.25)
Other Expenses	29,931,756	2.62	45,680,626	4.23	15,748,870	1.61
Indirect Cost Allocation, Occupancy	4,486,730	0.39	5,338,558	0.49	851,828	0.10
Total Administrative Expenses	230,780,376	20.23	259,121,805	24.01	28,341,429	3.78
NET INCOME (LOSS) FROM OPERATIONS	636,300,666	55.77	(29,948,746)	(2.77)	666,249,412	58.54
INVESTMENT INCOME						
Interest Income	163,372,790	14.32	25,000,000	2.32	138,372,790	12.00
Realized Gain/(Loss) on Investments	(2,781,033)	(0.24)	-	0.00	(2,781,033)	(0.24)
Unrealized Gain/(Loss) on Investments	15,276,289	1.34	-	0.00	15,276,289	1.34
Total Investment Income	175,868,046	15.42	25,000,000	2.32	150,868,046	13.10
NET RENTAL INCOME/EXPENSE	(207,814)	(0.02)	(902,553)	(0.08)	694,739	0.06
NET MCO TAX	551,456	0.05	-	0.00	551,456	0.05
GRANT EXPENSE	(32,025,455)	(2.81)	(32,038,636)	(2.97)	13,182	0.16
OTHER INCOME/EXPENSE	(829,898)	(0.07)	-	0.00	(829,898)	(0.07)
CHANGE IN NET ASSETS	**779,657,000**	**68.34**	**(37,889,935)**	**(3.51)**	**817,546,936**	**71.85**
MEDICAL LOSS RATIO	**83.8%**		**94.3%**		**(10.4%)**	
ADMINISTRATIVE LOSS RATIO	**4.3%**		**6.5%**		**2.2%**	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending June 30, 2024

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	561,217	340,086	901,303	17,253		496	483	919,052
REVENUES								
Capitation Revenue	$ 520,585,696	$ 373,045,415	$ 893,631,110	$ 32,857,486	$ -	$ 4,285,677	$ 215,394	$ 930,989,668
Total Operating Revenue	**520,585,696**	**373,045,415**	**893,631,110**	**32,857,486**	**-**	**4,285,677**	**215,394**	**930,989,668**
MEDICAL EXPENSES								
Provider Capitation	59,729,003	47,896,093	107,625,096	14,821,957				122,447,054
Claims	71,831,239	51,951,374	123,782,613	6,893,281	(64,552)	1,856,475		132,467,817
MLTSS	43,400,853	5,785,376	49,186,229		(8,642)	5,927	30,816	49,214,331
Prescription Drugs	-			8,097,717		578,360		8,676,077
Case Mgmt & Other Medical	84,431,237	50,842,392	135,273,629	1,446,605	(214,318)	1,236,485	144,817	137,887,219
Total Medical Expenses	**259,392,332**	**156,475,235**	**415,867,568**	**31,259,561**	**(287,512)**	**3,677,247**	**175,633**	**450,692,497**
Medical Loss Ratio	*49.8%*	*41.9%*	*46.5%*	*95.1%*	*0.0%*	*85.8%*	*81.5%*	*48.4%*
GROSS MARGIN	**261,193,363**	**216,570,179**	**477,763,543**	**1,597,925**	**287,512**	**608,431**	**39,762**	**480,297,172**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			13,521,932	985,455		141,933	95,867	14,745,187
Non-Salary Operating Expenses			4,000,262	730,688		(21,579)	1,333	4,710,704
Depreciation & Amortization			811,260			939		812,199
Other Operating Expenses			3,315,190	115,911		15,321	13,220	3,459,641
Indirect Cost Allocation, Occupancy			(168,720)	644,546		10,466	1,234	487,526
Total Administrative Expenses			**21,479,923**	**2,476,599**	**-**	**147,079**	**111,654**	**24,215,256**
Administrative Loss Ratio			*2.4%*	*7.5%*	*0.0%*	*3.4%*	*51.8%*	*2.6%*
Operating Income/(Loss)			**456,283,620**	**(878,674)**	**287,512**	**461,351**	**(71,892)**	**456,081,916**
Investments and Other Non-Operating			(252,562)					13,444,511
CHANGE IN NET ASSETS			**$ 456,031,058**	**$ (878,674)**	**$ 287,512**	**$ 461,351**	**$ (71,892)**	**$ 469,526,427**
BUDGETED CHANGE IN NET ASSETS			(6,769,199)	(2,496,046)	-	110,368	(69,955)	(8,234,059)
Variance to Budget - Fav/(Unfav)			$ 462,800,257	$ 1,617,372	$ 287,512	$ 350,983	$ (1,937)	$ 477,760,486

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ending June 30, 2024

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	6,993,236	4,200,004	11,193,240	209,851		5,486	5,893	11,408,577
REVENUES								
Capitation Revenue	$ 2,890,266,540	$ 2,020,584,630	$ 4,910,851,169	$ 408,847,800	$ (1,367,196)	$ 47,473,870	$ 2,568,926	$ 5,368,374,569
Total Operating Revenue	**2,890,266,540**	**2,020,584,630**	**4,910,851,169**	**408,847,800**	**(1,367,196)**	**47,473,870**	**2,568,926**	**5,368,374,569**
MEDICAL EXPENSES								
Provider Capitation	715,475,999	570,254,178	1,285,730,177	177,859,584				1,463,589,761
Claims	917,126,186	593,649,559	1,510,775,745	78,067,735	53,079	19,581,500		1,608,478,059
MLTSS	515,520,874	67,726,710	583,247,583	-	(27,145)	(4,176)	319,143	583,535,404
Prescription Drugs	(11,660)		(11,660)	97,891,784	(1,822,942)	6,150,537		102,207,719
Case Mgmt & Other Medical	435,892,640	274,523,744	710,416,384	17,425,490	(161,910)	14,009,516	1,793,104	743,482,584
Total Medical Expenses	**2,584,004,038**	**1,506,154,191**	**4,090,158,229**	**371,244,593**	**(1,958,918)**	**39,737,377**	**2,112,246**	**4,501,293,527**
Medical Loss Ratio	*89.4%*	*74.5%*	*83.3%*	*90.8%*	*143.3%*	*83.7%*	*82.2%*	*83.8%*
GROSS MARGIN	**306,262,502**	**514,430,439**	**820,692,940**	**37,603,207**	**591,722**	**7,736,493**	**456,680**	**867,081,042**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			134,029,759	12,015,719	(0)	1,933,018	1,117,754	149,096,250
Non-Salary Operating Expenses			34,195,498	4,552,094	(4,364)	497,736	16,048	39,257,012
Depreciation & Amortization			7,995,324			13,304		8,008,628
Other Operating Expenses			28,943,929	802,881		108,416	76,530	29,931,756
Indirect Cost Allocation, Occupancy			(6,919,497)	11,160,398		175,704	70,124	4,486,730
Total Administrative Expenses			**198,245,014**	**28,531,092**	**(4,364)**	**2,728,177**	**1,280,457**	**230,780,376**
Administrative Loss Ratio			*4.0%*	*7.0%*	*0.3%*	*5.7%*	*49.8%*	*4.3%*
Operating Income/(Loss)			**622,447,927**	**9,072,115**	**596,086**	**5,008,316**	**(823,777)**	**636,300,666**
Investments and Other Non-Operating			(278,442)					143,356,334
CHANGE IN NET ASSETS			**$ 622,169,484**	**$ 9,072,115**	**$ 596,086**	**$ 5,008,316**	**$ (823,777)**	**$ 779,657,000**
BUDGETED CHANGE IN NET ASSETS			(685,663)	(28,481,719)	-	98,983	(880,347)	(37,889,935)
Variance to Budget - Fav/(Unfav)			$ 622,855,147	$ 37,553,834	$ 596,086	$ 4,909,333	$ 56,570	$ 817,546,936

CalOptima Health

Unaudited Financial Statements as of June 30, 2024

MONTHLY RESULTS:

- Change in Net Assets is $469.5 million, favorable to budget $477.8 million
- Operating surplus is $456.1 million, with a surplus in non-operating income of $13.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $779.7 million, $817.5 million favorable to budget
- Operating surplus is $636.3 million, with a surplus in non-operating income of $143.4 million

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

June 2024				July 2023 - June 2024		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
456.3	(6.8)	463.1	Medi-Cal	622.4	(0.7)	623.1
(0.9)	(2.5)	1.6	OneCare	9.1	(28.5)	37.6
0.3	0.0	0.3	OCC	0.6	0.0	0.6
0.5	0.1	0.4	PACE	5.0	0.1	4.9
(0.1)	(0.1)	0.0	MSSP	(0.8)	(0.9)	0.1
456.1	**(9.2)**	**465.3**	**Total Operating Income (Loss)**	**636.3**	**(29.9)**	**666.2**
			Non-Operating Income (Loss)			
16.3	2.1	14.2	Net Investment Income/Expense	175.9	25.0	150.9
0.0	(0.1)	0.1	Net Rental Income/Expense	(0.2)	(0.9)	0.7
(0.3)	0.0	(0.3)	Net Operating Tax	0.6	0.0	0.6
(2.5)	(1.0)	(1.5)	Grant Expense	(32.0)	(32.0)	0.0
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	(0.8)	0.0	(0.8)
13.4	**1.0**	**12.5**	**Total Non-Operating Income/(Loss)**	**143.4**	**(7.9)**	**151.3**
469.5	**(8.2)**	**477.8**	**TOTAL**	**779.7**	**(37.9)**	**817.5**

CalOptima Health - Consolidated
Enrollment Summary
For the Twelve Months Ending June 30, 2024

June 2024					July 2023 - June 2024			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
139,602	131,452	8,150	6.2%	SPD	1,694,221	1,644,002	50,219	3.1%
275,019	266,863	8,156	3.1%	TANF Child	3,469,516	3,511,078	(41,562)	(1.2%)
134,360	123,760	10,600	8.6%	TANF Adult	1,669,412	1,548,172	121,240	7.8%
2,598	3,109	(511)	(16.4%)	LTC	33,016	37,397	(4,381)	(11.7%)
340,086	256,352	83,734	32.7%	MCE	4,200,004	3,703,532	496,472	13.4%
9,638	10,607	(969)	(9.1%)	WCM	127,071	131,742	(4,671)	(3.5%)
901,303	**792,143**	**109,160**	**13.8%**	**Medi-Cal Total**	**11,193,240**	**10,575,923**	**617,317**	**5.8%**
17,253	**17,387**	**(134)**	**(0.8%)**	**OneCare**	**209,851**	**211,878**	**(2,027)**	**(1.0%)**
496	**508**	**(12)**	**(2.4%)**	**PACE**	**5,486**	**5,743**	**(257)**	**(4.5%)**
483	**568**	**(85)**	**(15.0%)**	**MSSP**	**5,893**	**6,816**	**(923)**	**(13.5%)**
919,052	**810,038**	**109,014**	**13.5%**	**CalOptima Health Total**	**11,408,577**	**10,793,544**	**615,033**	**5.7%**
				Enrollment (by Network)				
297,622	282,272	15,350	5.4%	HMO	3,411,096	3,384,313	26,783	0.8%
179,595	160,088	19,507	12.2%	PHC	2,229,097	2,076,337	152,760	7.4%
145,284	113,891	31,393	27.6%	Shared Risk Group	2,245,682	2,054,079	191,603	9.3%
278,802	235,892	42,910	18.2%	Fee for Service	3,307,365	3,061,194	246,171	8.0%
901,303	**792,143**	**109,160**	**13.8%**	**Medi-Cal Total**	**11,193,240**	**10,575,923**	**617,317**	**5.8%**
17,253	**17,387**	**(134)**	**(0)**	**OneCare**	**209,851**	**211,878**	**(2,027)**	**(0)**
496	**508**	**(12)**	**(2.4%)**	**PACE**	**5,486**	**5,743**	**(257)**	**(4.5%)**
483	**568**	**(85)**	**(15.0%)**	**MSSP**	**5,893**	**6,816**	**(923)**	**(13.5%)**
919,052	**810,038**	**109,014**	**13.5%**	**CalOptima Health Total**	**11,408,577**	**10,793,544**	**615,033**	**5.7%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287	14,179	14,193	14,222	14,337	16,258	16,563	16,462	16,482	16,535	16,094	183,879	177,829	6,050
TANF Child	69,607	69,928	69,010	69,620	69,177	68,696	65,998	65,784	76,870	68,123	67,749	67,424	827,986	956,416	(128,430)
TANF Adult	50,979	51,388	50,896	50,392	49,538	48,637	61,010	63,447	52,817	59,234	58,001	57,504	653,843	664,895	(11,052)
LTC		1			(1)	1	1	1					3		3
MCE	132,523	133,978	131,301	130,441	129,207	127,361	154,424	157,160	159,033	157,664	156,742	155,338	1,725,172	1,560,613	164,559
WCM	2,050	2,095	2,021	2,041	2,019	1,982	1,438	1,406	1,301	1,311	1,287	1,262	20,213	24,560	(4,347)
Total	269,426	271,677	267,407	266,687	264,162	261,014	299,129	304,361	306,483	302,814	300,314	297,622	3,411,096	3,384,313	**26,783**
PHCs															
SPD	4,581	4,599	4,623	4,588	4,705	4,770	4,525	4,754	4,731	4,693	4,701	4,524	55,794	50,830	4,964
TANF Child	147,946	148,557	145,969	145,186	144,127	143,149	142,068	141,456	154,158	143,416	142,294	141,660	1,739,986	1,650,473	89,513
TANF Adult	8,999	9,050	9,404	8,885	8,692	8,451	8,540	8,619	(4,493)	4,492	4,297	4,387	79,323	45,544	33,779
LTC										1			1		1
MCE	23,230	23,489	22,708	22,540	22,400	22,185	22,237	22,769	23,127	22,825	22,989	22,515	273,014	247,239	25,775
WCM	6,919	6,974	6,900	6,829	7,044	6,799	6,789	6,585	6,539	6,455	6,637	6,509	80,979	82,251	(1,272)
Total	191,675	192,669	189,604	188,028	186,968	185,354	184,159	184,183	184,062	181,882	180,918	179,595	2,229,097	2,076,337	**152,760**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982	10,833	10,803	6,448	6,775	6,798	6,802	6,961	6,770	106,630	102,094	4,536
TANF Child	55,211	55,471	54,427	53,505	52,934	52,285	31,419	31,364	36,668	32,982	32,887	32,949	522,102	546,260	(24,158)
TANF Adult	43,118	43,425	42,894	42,250	41,524	40,564	26,809	29,619	27,157	30,357	29,636	29,652	427,005	363,014	63,991
LTC	1	1			2	2		2		2	2		12		12
MCE	124,149	125,749	122,600	121,935	120,343	117,859	70,007	72,870	76,078	75,930	75,513	75,184	1,178,217	1,030,186	148,031
WCM	1,234	1,247	1,180	1,165	1,190	1,129	800	768	733	749	792	729	11,716	12,525	(809)
Total	**234,923**	**237,030**	**232,212**	**229,837**	**226,826**	**222,642**	**135,483**	**141,398**	**147,434**	**146,822**	**145,791**	**145,284**	**2,245,682**	**2,054,079**	**191,603**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630	100,115	100,302	93,362	95,142	95,771	96,712	97,782	97,711	1,175,351	1,164,232	11,119
TANF Child									6	3	1	1	11	24	(13)
TANF Adult	2,442	2,397	2,370	2,307	2,247	2,150	1,888	1,694	1,604	1,473	1,381	1,322	23,275	29,703	(6,428)
LTC	2,661	2,630	2,612	2,492	2,525	2,421	2,411	2,350	2,239	2,302	2,284	2,321	29,248	32,979	(3,731)
MCE	8,968	9,230	9,418	9,312	9,117	8,759	7,761	7,209	6,465	5,971	5,372	5,856	93,438	105,734	(12,296)
WCM	15	14	14	13	13	10	6	7	7	6	8	7	120	218	(98)
Total	**113,328**	**114,103**	**114,164**	**113,754**	**114,017**	**113,642**	**105,428**	**106,402**	**106,092**	**106,467**	**106,828**	**107,218**	**1,321,443**	**1,332,890**	**(11,447)**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921	14,278	14,643	14,683	14,612	14,735	14,899	15,039	14,503	172,567	149,017	23,550
TANF Child	29,143	30,159	31,025	29,500	29,973	30,070	31,492	31,523	36,862	33,699	33,000	32,985	379,431	357,905	21,526
TANF Adult	37,044	37,794	37,966	37,126	36,903	36,189	54,765	47,862	36,755	40,974	41,093	41,495	485,966	445,016	40,950
LTC	349	360	345	327	318	331	316	263	300	294	272	277	3,752	4,418	(666)
MCE	70,923	73,165	72,983	71,223	71,263	71,175	90,156	84,788	80,568	81,787	80,939	81,193	930,163	759,760	170,403
WCM	1,164	1,259	1,212	1,129	1,166	1,114	1,161	1,224	1,126	1,168	1,189	1,131	14,043	12,188	1,855
Total	**152,142**	**156,515**	**157,488**	**153,226**	**153,901**	**153,522**	**192,573**	**180,272**	**170,346**	**172,821**	**171,532**	**171,584**	**1,985,922**	**1,728,304**	**257,618**
Grand Totals															
SPD	142,819	143,633	143,620	143,314	144,153	144,855	135,276	137,846	138,497	139,588	141,018	139,602	1,694,221	1,644,002	50,219
TANF Child	301,907	304,115	300,431	297,811	296,211	294,200	270,977	270,127	304,564	278,223	275,931	275,019	3,469,516	3,511,078	(41,562)
TANF Adult	142,582	144,054	143,530	140,960	138,904	135,991	153,012	151,241	113,840	136,530	134,408	134,360	1,669,412	1,548,172	121,240
LTC	3,011	2,992	2,957	2,819	2,844	2,755	2,728	2,616	2,539	2,599	2,558	2,598	33,016	37,397	(4,381)
MCE	359,793	365,611	359,010	355,451	352,330	347,339	344,585	344,796	345,271	344,177	341,555	340,086	4,200,004	3,703,532	496,472
WCM	11,382	11,589	11,327	11,177	11,432	11,034	10,194	9,990	9,706	9,689	9,913	9,638	127,071	131,742	(4,671)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**	**945,874**	**936,174**	**916,772**	**916,616**	**914,417**	**910,806**	**905,383**	**901,303**	**11,193,240**	**10,575,923**	**617,317**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**	**17,648**	**17,593**	**17,380**	**17,300**	**17,277**	**17,138**	**17,159**	**17,253**	**209,851**	**211,878**	**(2,027)**
PACE	**429**	**432**	**437**	**442**	**446**	**447**	**453**	**457**	**474**	**486**	**487**	**496**	**5,486**	**5,743**	**(257)**
MSSP	**503**	**500**	**503**	**494**	**491**	**494**	**492**	**488**	**484**	**481**	**480**	**483**	**5,893**	**6,816**	**(923)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**	**963,968**	**954,214**	**934,605**	**934,373**	**932,168**	**928,430**	**923,029**	**919,052**	**11,408,577**	**10,793,544**	**615,033**

Note:* Total membership does not include MSSP

ENROLLMENT:

Overall, June enrollment was 919,052

- Favorable to budget 109,014 or 13.5%
- Decreased 3,977 or 0.4% from Prior Month (PM) (May 2024)
- Decreased 69,664 or 7.0% from Prior Year (PY) (June 2023)

Medi-Cal enrollment was 901,303

- Favorable to budget 109,160 or 13.8% due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts.
- Medi-Cal Expansion (MCE) favorable to budget 83,734
- Temporary Assistance for Needy Families (TANF) favorable to budget 18,756
- Seniors and Persons with Disabilities (SPD) favorable to budget 8,150
- Whole Child Model (WCM) unfavorable to budget 969
- Long-Term Care (LTC) unfavorable to budget 511
- Decreased 4,080 from PM

OneCare enrollment was 17,253

- Unfavorable to budget 134 or 0.8%
- Increased 94 from PM

PACE enrollment was 496

- Unfavorable to budget 12 or 2.4%
- Increased 9 from PM

MSSP enrollment was 483

- Unfavorable to budget 85 or 15.0% due to MSSP currently being understaffed. There is a staff to member ratio that must be met.
- Increased 3 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
901,303	**792,143**	**109,160**	**13.8%**	**Member Months**	**11,193,240**	**10,575,923**	**617,317**	**5.8%**
				Revenues				
893,631,110	270,715,011	622,916,099	230.1%	Medi-Cal Capitation Revenue	4,910,851,169	3,578,731,343	1,332,119,826	37.2%
893,631,110	**270,715,011**	**622,916,099**	**230.1%**	**Total Operating Revenue**	**4,910,851,169**	**3,578,731,343**	**1,332,119,826**	**37.2%**
				Medical Expenses				
107,625,096	92,984,573	(14,640,523)	(15.7%)	Provider Capitation	1,285,730,177	1,209,261,687	(76,468,490)	(6.3%)
50,886,286	60,756,175	9,869,889	16.2%	Facilities Claims	783,973,695	824,397,456	40,423,761	4.9%
72,896,327	41,116,564	(31,779,763)	(77.3%)	Professional Claims	726,802,050	534,047,318	(192,754,732)	(36.1%)
49,186,229	49,266,462	80,233	0.2%	MLTSS	583,247,583	608,348,655	25,101,072	4.1%
-	-	-	0.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
17,344,615	5,591,934	(11,752,681)	(210.2%)	Incentive Payments	183,347,782	77,080,606	(106,267,176)	(137.9%)
9,532,650	7,632,280	(1,900,370)	(24.9%)	Medical Management	85,531,246	92,087,699	6,556,453	7.1%
108,396,364	989,250	(107,407,114)	(10,857.4%)	Other Medical Expenses	441,537,357	12,029,293	(429,508,064)	(3,570.5%)
415,867,568	**258,337,238**	**(157,530,330)**	**(61.0%)**	**Total Medical Expenses**	**4,090,158,229**	**3,357,252,714**	**(732,905,515)**	**(21.8%)**
477,763,543	**12,377,773**	**465,385,770**	**3,759.9%**	**Gross Margin**	**820,692,940**	**221,478,629**	**599,214,311**	**270.6%**
				Administrative Expenses				
13,521,932	10,626,635	(2,895,297)	(27.2%)	Salaries, Wages & Employee Benefits	134,029,759	133,455,069	(574,690)	(0.4%)
1,404,637	1,200,788	(203,849)	(17.0%)	Professional Fees	9,642,777	12,978,835	3,336,058	25.7%
2,169,384	2,915,042	745,658	25.6%	Purchased Services	19,623,352	27,224,770	7,601,418	27.9%
426,240	634,010	207,770	32.8%	Printing & Postage	4,929,369	5,643,680	714,311	12.7%
811,260	400,000	(411,260)	(102.8%)	Depreciation & Amortization	7,995,324	4,800,000	(3,195,324)	(66.6%)
3,315,190	3,896,591	581,401	14.9%	Other Operating Expenses	28,943,929	44,375,033	15,431,104	34.8%
(168,720)	(526,094)	(357,374)	(67.9%)	Indirect Cost Allocation, Occupancy	(6,919,497)	(6,313,095)	606,402	9.6%
21,479,923	**19,146,972**	**(2,332,951)**	**(12.2%)**	**Total Administrative Expenses**	**198,245,014**	**222,164,292**	**23,919,278**	**10.8%**
				Non-Operating Income (Loss)				
(252,577)	-	(252,577)	(100.0%)	Net Operating Tax	551,456	-	551,456	100.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	0	-	0	100.0%
15	-	15	100.0%	Other Income/Expense	(829,898)	-	(829,898)	(100.0%)
(252,562)	**-**	**(252,562)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(278,442)**	**-**	**(278,442)**	**(100.0%)**
456,031,058	**(6,769,199)**	**462,800,257**	**6,836.9%**	**Change in Net Assets**	**622,169,484**	**(685,663)**	**622,855,147**	**90,839.8%**
46.5%	***95.4%***	***(48.9%)***		***Medical Loss Ratio***	***83.3%***	***93.8%***	***(10.5%)***	
2.4%	***7.1%***	***4.7%***		***Admin Loss Ratio***	***4.0%***	***6.2%***	***2.2%***	

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES of $893.6 million are favorable to budget $622.9 million driven by:

- Favorable volume related variance of $37.3 million
- Favorable price related variance of $585.6 million
    - $647.0 million due to release of Calendar Years (CY) 2021 to 2023 COVID-19 risk corridor estimates
    - $9.8 million due to logic update for maternity kick supplemental payments
    - Offset by:
        - $54.3 million due to CY 2023 rate adjustments by the Department of Health Care Services (DHCS)
        - $11.1 million from CY 2024 Unsatisfactory Immigration Status (UIS) risk corridor

MEDICAL EXPENSES of $415.9 million are unfavorable to budget $157.5 million driven by:

- Unfavorable volume related variance of $35.6 million
- Unfavorable price related variance of $121.9 million due to:
    - Other Medical Expenses unfavorable variance of $107.3 million due primarily to CY 2024 Community Reinvestment and Quality Achievement accruals
    - Professional Claims expense unfavorable variance of $26.1 million due primarily to Community Support (CS) services and increase in utilization
    - Incentive Payments expense unfavorable variance of $11.0 million due to $6.1 million from Student Behavioral Health Incentive Program (SBHIP) and $5.1 million from Housing and Homelessness Incentive Program (HHIP)
    - Offset by:
        - Facilities Claims expense favorable variance of $18.2 million due to lower than expected utilization
        - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $6.9 million due to lower than expected utilization

MEDI-CAL INCOME STATEMENT– JUNE MONTH: (cont.)

ADMINISTRATIVE EXPENSES of $21.5 million are unfavorable to budget $2.3 million driven by:

- Salaries, Wages & Employee Benefits expense unfavorable to budget $2.9 million due primarily to changes in CalOptima Health's Total Other Post-Employment Benefits (OPEB) and Pension liabilities
- Non-Salary expenses favorable to budget $0.6 million

CHANGE IN NET ASSETS is $456.0 million, favorable to budget $462.8 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,253	**17,387**	**(134)**	**(0.8%)**	**Member Months**	**209,851**	**211,878**	**(2,027)**	**(1.0%)**
				Revenues				
24,578,005	23,216,825	1,361,180	5.9%	Medicare Part C Revenue	305,990,092	278,564,828	27,425,264	9.8%
8,279,481	8,690,490	(411,009)	(4.7%)	Medicare Part D Revenue	102,857,707	105,146,987	(2,289,280)	(2.2%)
32,857,486	**31,907,315**	**950,171**	**3.0%**	**Total Operating Revenue**	**408,847,800**	**383,711,815**	**25,135,985**	**6.6%**
				Medical Expenses				
14,821,957	15,041,701	219,744	1.5%	Provider Capitation	177,859,584	170,221,061	(7,638,523)	(4.5%)
4,946,019	3,713,694	(1,232,325)	(33.2%)	Inpatient	58,656,727	54,096,463	(4,560,264)	(8.4%)
1,947,262	1,223,067	(724,195)	(59.2%)	Ancillary	19,411,008	16,241,043	(3,169,965)	(19.5%)
-	80,155	80,155	100.0%	MLTSS	-	976,757	976,757	100.0%
8,097,717	9,865,045	1,767,328	17.9%	Prescription Drugs	97,891,784	118,367,541	20,475,757	17.3%
621,382	349,259	(272,123)	(77.9%)	Incentive Payments	5,613,837	4,359,097	(1,254,740)	(28.8%)
825,224	1,187,960	362,736	30.5%	Medical Management	11,810,303	14,988,449	3,178,146	21.2%
-	-	-	0.0%	Other Medical Expenses	1,350	-	(1,350)	(100.0%)
31,259,561	**31,460,881**	**201,320**	**0.6%**	**Total Medical Expenses**	**371,244,593**	**379,250,411**	**8,005,818**	**2.1%**
1,597,925	**446,434**	**1,151,491**	**257.9%**	**Gross Margin**	**37,603,207**	**4,461,404**	**33,141,803**	**742.9%**
				Administrative Expenses				
985,455	1,127,962	142,507	12.6%	Salaries, Wages & Employee Benefits	12,015,719	14,061,582	2,045,863	14.5%
210,425	169,500	(40,925)	(24.1%)	Professional Fees	626,955	999,000	372,046	37.2%
374,495	357,712	(16,783)	(4.7%)	Purchased Services	2,624,933	3,468,790	843,857	24.3%
145,768	204,348	58,580	28.7%	Printing & Postage	1,300,206	1,927,450	627,244	32.5%
115,911	134,371	18,460	13.7%	Other Operating Expenses	802,881	1,103,301	300,420	27.2%
644,546	948,587	304,042	32.1%	Indirect Cost Allocation, Occupancy	11,160,398	11,383,000	222,602	2.0%
2,476,599	**2,942,480**	**465,881**	**15.8%**	**Total Administrative Expenses**	**28,531,092**	**32,943,123**	**4,412,031**	**13.4%**
(878,674)	**(2,496,046)**	**1,617,372**	**64.8%**	**Change in Net Assets**	**9,072,115**	**(28,481,719)**	**37,553,834**	**131.9%**
95.1%	***98.6%***	***(3.5%)***		***Medical Loss Ratio***	***90.8%***	***98.8%***	***(8.0%)***	
7.5%	***9.2%***	***1.7%***		***Admin Loss Ratio***	***7.0%***	***8.6%***	***1.6%***	

Preliminary

ONECARE INCOME STATEMENT– JUNE MONTH:

REVENUES of $32.9 million are favorable to budget $1.0 million driven by:

- Unfavorable volume related variance of $0.2 million
- Favorable price related variance of $1.2 million

MEDICAL EXPENSES of $31.3 million are favorable to budget $0.2 million driven by:

- Favorable volume related variance of $0.2 million

ADMINISTRATIVE EXPENSES of $2.5 million are favorable to budget $0.5 million driven by:

- Non-Salary expenses favorable to budget $0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.9) million, favorable to budget $1.6 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Revenue	22,753	-	22,753	100.0%
-	-	-	0.0%	Medicare Part D Revenue	(1,389,949)	-	(1,389,949)	(100.0%)
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**(1,367,196)**	**-**	**(1,367,196)**	**(100.0%)**
				Medical Expenses				
(64,511)	-	64,511	100.0%	Facilities Claims	(532,735)	-	532,735	100.0%
(41)	-	41	100.0%	Ancillary	585,814	-	(585,814)	(100.0%)
(8,642)	-	8,642	100.0%	MLTSS	(27,145)	-	27,145	100.0%
-	-	-	0.0%	Prescription Drugs	(1,822,942)	-	1,822,942	100.0%
(214,111)	-	214,111	100.0%	Incentive Payments	(109,101)	-	109,101	100.0%
(207)	-	207	100.0%	Medical Management	(52,809)	-	52,809	100.0%
(287,512)	**-**	**287,512**	**100.0%**	**Total Medical Expenses**	**(1,958,918)**	**-**	**1,958,918**	**100.0%**
287,512	**-**	**287,512**	**100.0%**	**Gross Margin**	**591,722**	**-**	**591,722**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Purchased Services	(4,364)	-	4,364	100.0%
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**(4,364)**	**-**	**4,364**	**100.0%**
287,512	**-**	**287,512**	**100.0%**	**Change in Net Assets**	**596,086**	**-**	**596,086**	**100.0%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***143.3%***	***0.0%***	***143.3%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
496	**508**	**(12)**	**(2.4%)**	**Member Months**	**5,486**	**5,743**	**(257)**	**(4.5%)**
				Revenues				
3,182,276	3,314,289	(132,013)	(4.0%)	Medi-Cal Capitation Revenue	35,257,645	37,351,530	(2,093,885)	(5.6%)
747,859	842,798	(94,939)	(11.3%)	Medicare Part C Revenue	8,888,204	9,431,635	(543,431)	(5.8%)
355,543	231,886	123,657	53.3%	Medicare Part D Revenue	3,328,021	2,624,479	703,542	26.8%
4,285,677	**4,388,973**	**(103,296)**	**(2.4%)**	**Total Operating Revenue**	**47,473,870**	**49,407,644**	**(1,933,774)**	**(3.9%)**
				Medical Expenses				
1,236,485	1,235,212	(1,273)	(0.1%)	Medical Management	14,009,516	14,785,811	776,295	5.3%
738,501	981,423	242,922	24.8%	Facilities Claims	8,436,651	11,160,677	2,724,026	24.4%
785,513	887,946	102,433	11.5%	Professional Claims	8,354,303	10,509,528	2,155,225	20.5%
578,360	522,271	(56,089)	(10.7%)	Prescription Drugs	6,150,537	5,779,360	(371,177)	(6.4%)
5,927	124,140	118,213	95.2%	MLTSS	(4,176)	1,451,607	1,455,783	100.3%
332,461	285,640	(46,821)	(16.4%)	Patient Transportation	2,790,546	2,910,663	120,117	4.1%
3,677,247	**4,036,632**	**359,385**	**8.9%**	**Total Medical Expenses**	**39,737,377**	**46,597,646**	**6,860,269**	**14.7%**
608,431	**352,341**	**256,090**	**72.7%**	**Gross Margin**	**7,736,493**	**2,809,998**	**4,926,495**	**175.3%**
				Administrative Expenses				
141,933	199,815	57,882	29.0%	Salaries, Wages & Employee Benefits	1,933,018	2,205,680	272,662	12.4%
3,959	4,901	942	19.2%	Professional Fees	323,674	58,845	(264,829)	(450.0%)
(25,598)	16,471	42,069	255.4%	Purchased Services	163,056	132,495	(30,561)	(23.1%)
59	(5,257)	(5,316)	(101.1%)	Printing & Postage	11,005	11,850	845	7.1%
939	900	(39)	(4.3%)	Depreciation & Amortization	13,304	10,800	(2,504)	(23.2%)
15,321	10,272	(5,049)	(49.2%)	Other Operating Expenses	108,416	112,992	4,576	4.1%
10,466	14,871	4,405	29.6%	Indirect Cost Allocation, Occupancy	175,704	178,353	2,649	1.5%
147,079	**241,973**	**94,894**	**39.2%**	**Total Administrative Expenses**	**2,728,177**	**2,711,015**	**(17,162)**	**(0.6%)**
461,351	**110,368**	**350,983**	**318.0%**	**Change in Net Assets**	**5,008,316**	**98,983**	**4,909,333**	**4,959.8%**
85.8%	***92.0%***	***(6.2%)***		***Medical Loss Ratio***	***83.7%***	***94.3%***	***(10.6%)***	
3.4%	***5.5%***	***2.1%***		***Admin Loss Ratio***	***5.7%***	***5.5%***	***(0.3%)***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
483	**568**	**(85)**	**(15.0%)**	**Member Months**	**5,893**	**6,816**	**(923)**	**(13.5%)**
				Revenues				
215,394	253,510	(38,116)	(15.0%)	Revenue	2,568,926	3,042,208	(473,282)	(15.6%)
215,394	**253,510**	**(38,116)**	**(15.0%)**	**Total Operating Revenue**	**2,568,926**	**3,042,208**	**(473,282)**	**(15.6%)**
				Medical Expenses				
144,817	185,729	40,912	22.0%	Medical Management	1,793,104	2,223,693	430,589	19.4%
30,816	32,960	2,144	6.5%	Waiver Services	319,143	395,487	76,344	19.3%
144,817	185,729	40,912	22.0%	Total Medical Management	1,793,104	2,223,693	430,589	19.4%
30,816	32,960	2,144	6.5%	Total Waiver Services	319,143	395,487	76,344	19.3%
175,633	**218,689**	**43,056**	**19.7%**	**Total Program Expenses**	**2,112,246**	**2,619,180**	**506,934**	**19.4%**
39,762	**34,821**	**4,941**	**14.2%**	**Gross Margin**	**456,680**	**423,028**	**33,652**	**8.0%**
				Administrative Expenses				
95,867	88,487	(7,380)	(8.3%)	Salaries, Wages & Employee Benefits	1,117,754	1,107,775	(9,979)	(0.9%)
1,333	1,337	4	0.3%	Professional Fees	16,000	16,000	-	0.0%
-	-	-	0.0%	Purchased Services	48	-	(48)	(100.0%)
13,220	7,427	(5,793)	(78.0%)	Other Operating Expenses	76,530	89,300	12,770	14.3%
1,234	7,525	6,291	83.6%	Indirect Cost Allocation, Occupancy	70,124	90,300	20,176	22.3%
111,654	**104,776**	**(6,878)**	**(6.6%)**	**Total Administrative Expenses**	**1,280,457**	**1,303,375**	**22,918**	**1.8%**
(71,892)	**(69,955)**	**(1,937)**	**(2.8%)**	**Change in Net Assets**	**(823,777)**	**(880,347)**	**56,570**	**6.4%**
81.5%	***86.3%***	***(4.7%)***		***Medical Loss Ratio***	***82.2%***	***86.1%***	***(3.9%)***	
51.8%	***41.3%***	***(10.5%)***		***Admin Loss Ratio***	***49.8%***	***42.8%***	***(7.0%)***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
44,360	50,472	6,112	12.1%	Purchased Services	541,923	491,275	(50,648)	(10.3%)
180,854	211,000	30,146	14.3%	Depreciation & Amortization	2,147,234	2,532,000	384,766	15.2%
24,795	34,000	9,205	27.1%	Insurance Expense	279,208	408,000	128,792	31.6%
171,256	138,700	(32,556)	(23.5%)	Repair & Maintenance	1,507,960	1,778,822	270,862	15.2%
44,341	57,859	13,518	23.4%	Other Operating Expenses	662,549	694,308	31,759	4.6%
(465,605)	(492,031)	(26,426)	(5.4%)	Indirect Cost Allocation, Occupancy	(5,138,875)	(5,904,405)	(765,530)	(13.0%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	133,808	22,615	16.9%	Rental Income	1,881,167	1,605,718	275,449	17.2%
156,423	**133,808**	**22,615**	**16.9%**	**Total Operating Revenue**	**1,881,167**	**1,605,718**	**275,449**	**17.2%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
30,496	31,145	649	2.1%	Purchased Services	353,383	277,636	(75,747)	(27.3%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	414,875	480,000	65,125	13.6%
8,135	10,086	1,951	19.3%	Insurance Expense	94,515	121,087	26,572	21.9%
54,185	60,842	6,657	10.9%	Repair & Maintenance	535,308	826,197	290,889	35.2%
15,118	24,445	9,327	38.2%	Other Operating Expenses	264,016	293,351	29,335	10.0%
142,508	**166,518**	**24,010**	**14.4%**	**Total Administrative Expenses**	**1,662,098**	**1,998,271**	**336,174**	**16.8%**
13,915	**(32,710)**	**46,625**	**142.5%**	**Change in Net Assets**	**219,069**	**(392,553)**	**611,622**	**155.8%**

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
31,080	56,664	25,584	45.1%	Purchased Services	238,528	510,000	271,472	53.2%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	84,577	-	(84,577)	(100.0%)
4,415	-	(4,415)	(100.0%)	Insurance Expense	39,731	-	(39,731)	(100.0%)
6,098	-	(6,098)	(100.0%)	Repair & Maintenance	51,718	-	(51,718)	(100.0%)
1,514	-	(1,514)	(100.0%)	Other Operating Expenses	12,330	-	(12,330)	(100.0%)
52,504	**56,664**	**4,160**	**7.3%**	**Total Administrative Expenses**	**426,884**	**510,000**	**83,116**	**16.3%**
(52,504)	**(56,664)**	**4,160**	**7.3%**	**Change in Net Assets**	**(426,884)**	**(510,000)**	**83,116**	**16.3%**

Preliminary

OTHER PROGRAM INCOME STATEMENTS – JUNE MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is $0.3 million, favorable to budget $0.3 million due to PY activities

PACE

- **CHANGE IN NET ASSETS** is $0.5 million, favorable to budget $0.4 million

MSSP

- **CHANGE IN NET ASSETS** is ($71,892), unfavorable to budget $1,937

NON-OPERATING INCOME STATEMENTS – JUNE MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is $13,915, favorable to budget $46,625
  - Net of $156,423 in rental income and $142,508 in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($52,504), favorable to budget $4,160

INVESTMENT INCOME

- Favorable variance of $14.2 million due to $12.7 million of interest income and $1.5 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
June 30, 2024

	June-24	May-24	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	527,999,317	942,948,212	(414,948,895)	(44.0%)
Short-term Investments	1,777,895,940	1,816,280,186	(38,384,246)	(2.1%)
Premiums due from State of CA and CMS	550,648,615	572,403,715	(21,755,100)	(3.8%)
Prepaid Expenses and Other	11,169,119	13,713,699	(2,544,580)	(18.6%)
Total Current Assets	**2,867,712,992**	**3,345,345,813**	**(477,632,821)**	**(14.3%)**
Board Designated Assets				
Board Designated Reserves	1,005,885,164	503,748,780	502,136,384	99.7%
Statutory Designated Reserves	131,878,274	130,969,751	908,523	0.7%
Total Designated Assets	**1,137,763,438**	**634,718,531**	**503,044,907**	**79.3%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**96,560,808**	**95,890,834**	**669,974**	**0.7%**
Total Assets	**4,102,337,238**	**4,076,255,178**	**26,082,060**	**0.6%**
Deferred Outflows of Resources				
Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
Net Pension	24,549,290	24,373,350	175,940	0.7%
Other Postemployment Benefits	1,350,000	1,596,000	(246,000)	(15.4%)
Total Deferred Outflows of Resources	**75,899,007**	**75,969,067**	**(70,060)**	**(0.1%)**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,178,236,245**	**4,152,224,245**	**26,012,000**	**0.6%**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,143,632,594	1,692,431,791	(548,799,197)	(32.4%)
Provider Capitation and Withholds	167,506,321	168,796,501	(1,290,180)	(0.8%)
Accrued Reinsurance Costs to Providers	7,511,531	9,685,629	(2,174,098)	(22.4%)
Unearned Revenue	15,261,163	72,822,274	(57,561,111)	(79.0%)
Accounts Payable and Other	172,319,606	121,663,608	50,655,998	41.6%
Accrued Payroll and Employee Benefits and Other	25,886,668	18,604,710	7,281,958	39.1%
Other Current Liabilities	107,501,732	19,946	107,481,786	538868.2%
Total Current Liabilities	**1,639,619,615**	**2,084,024,458**	**(444,404,843)**	**(21.3%)**
GASB 96 Subscription Liabilities	16,955,572	16,955,572	-	0.0%
Postemployment Health Care Plan	17,370,000	19,466,727	(2,096,727)	(10.8%)
Net Pension Liability	45,981,359	40,465,145	5,516,214	13.6%
Total Liabilities	**1,719,926,546**	**2,160,911,902**	**(440,985,356)**	**(20.4%)**
Deferred Inflows of Resources				
Net Pension	2,248,445	3,387,516	(1,139,071)	(33.6%)
Other Postemployment Benefits	6,398,000	7,788,000	(1,390,000)	(17.8%)
Total Deferred Inflows of Resources	**8,646,445**	**11,175,516**	**(2,529,071)**	**(22.6%)**
Net Position				
Required TNE	127,508,151	122,700,902	4,807,248	3.9%
Funds in excess of TNE	2,322,155,103	1,857,435,925	464,719,178	25.0%
Total Net Position	**2,449,663,254**	**1,980,136,827**	**469,526,427**	**23.7%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,178,236,245**	**4,152,224,245**	**26,012,000**	**0.6%**

BALANCE SHEET – JUNE MONTH:

ASSETS of $4.2 billion increased $26.0 million from May or 0.6%

- Operating Cash and Short-term Investments net decrease of $453.3 million due to a transfer of $500.0 million from operating cash to the Board reserve account, offset by a lower Medi-Cal capitation payment due to WCM retrospective risk corridor
- Total Designated Assets increased $503.0 million due to the transfer of $500.0 million from operating cash to Board Designated Reserves based on a policy change for increasing the range of the Board Designated fund.

LIABILITIES of $1.7 billion decreased $441.0 million from May or 20.4%

- Medical Claims Liabilities decreased $548.8 million due primarily to $647.0 million release of CY 2021-2023 COVID-19 risk corridor accrual offset in increase in Payables Due to DHCS
- Unearned Revenue decreased $57.6 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)
- Other Current Liabilities increased $107.5 million due to the State's statutory calculation and requirement for Community Reinvestment.
- Accounts Payable and Other increased $50.7 million due primarily to the Managed Care Organization (MCO) tax liability and related payments

NET ASSETS of $2.4 billion, increased $469.5 million from May or 23.7%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of June 30, 2024

Board Designated Reserves

	Investment Account Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Payden & Rygel Tier One	503,164,581				
	MetLife Tier One	502,720,583				
Board Designated Reserves		1,005,885,164	891,066,767	1,069,280,121	114,818,397	(63,394,957)
	Current Reserve Level	*2.82*	*2.50*	*3.00*		

Statutory Designated Reserves

	Investment Account Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Payden & Rygel Tier Two	66,117,950				
	MetLife Tier Two	65,760,324				
Statutory Designated Reserves		131,878,274	127,508,151	140,258,966	4,370,123	(8,380,692)
	Current Reserve Level	*1.03*	*1.00*	*1.10*		

CalOptima Health
Statement of Cash Flow
June 30, 2024

	June 2024	July 2023 - June 2024
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	469,526,427	779,657,000
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,037,024	10,655,314
Changes in assets and liabilities:		
Prepaid expenses and other	2,544,580	3,891,583
Capitation receivable	21,755,100	(76,724,917)
Medical claims liability	(550,973,295)	(489,094,639)
Deferred revenue	(57,561,111)	(48,181,748)
Payable to health networks	(1,290,180)	42,062,295
Accounts payable	50,655,998	157,237,663
Accrued payroll	10,701,446	6,465,491
Other accrued liabilities	107,481,786	108,294,280
Net cash provided by/(used in) operating activities	53,877,774	494,262,322
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	(2,459,011)	(52,458,728)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	38,384,246	(101,159,876)
Change in Property and Equipment	(1,706,997)	(23,008,617)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(503,044,907)	(561,211,744)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(466,367,658)	(685,380,237)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(414,948,895)	(243,576,643)
CASH AND CASH EQUIVALENTS, beginning of period	$942,948,212	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**527,999,317**	**527,999,317**

CalOptima Health
Spending Plan
For the Twelve Months Ending June 30, 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 6/30/2024	**$2,449.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,005.9**			**41.1%**
	Statutory Designated Reserve[1]	**$131.9**			**5.4%**
	Capital Assets, net of Depreciation[2]	**$96.6**			**3.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.7	$61.7	44.0	0.7%
	Housing and Homelessness Incentive Program[4]	22.2	87.4	65.2	0.9%
	Intergovernmental Transfers (IGT)	59.9	111.7	51.8	2.4%
	Digital Transformation and Workplace Modernization[5]	50.6	100.0	49.4	2.1%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.2	2.0	1.8	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.7	4.7	3.0	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	137.0	153.5	16.5	5.6%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	47.6	50.0	2.4	1.9%
	Distribution Event- Naloxone Grant	2.4	15.0	12.6	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	15.1	107.5	92.4	0.6%
	CalOptima Health Community Reinvestment Program	37.1	38.0	0.9	1.5%
	Outreach Strategy for newly eligible Adult Expansion members	4.4	5.0	0.6	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.0%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	526.2	526.2	0.0	21.5%
	Subtotal:	**$1,027.7**	**$1,417.8**	**$390.1**	**42.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$187.6**	**$526.2**		**7.7%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 113 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[5] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

CalOptima Health
Key Financial Indicators
As of June 30, 2024

	Item Name	June 2024					July 2023 - June 2024				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	919,052	810,038	109,014	13.5%		11,408,577	10,793,544	615,033	5.7%	
	Operating Revenue	930,989,668	307,264,809	623,724,859	203.0%		5,368,374,569	4,014,893,010	1,353,481,559	33.7%	
	Medical Expenses	450,692,497	294,053,440	(156,639,057)	(53.3%)		4,501,293,527	3,785,719,951	(715,573,576)	(18.9%)	
	General and Administrative Expense	24,215,256	22,436,201	(1,779,055)	(7.9%)		230,780,376	259,121,805	28,341,429	10.9%	
	Non-Operating Income/(Loss)	13,444,511	990,773	12,453,738	1,257.0%		143,356,334	(7,941,189)	151,297,524	1,905.2%	
	Summary of Income & Expenses	469,526,427	(8,234,059)	477,760,486	5,802.2%		779,657,000	(37,889,935)	817,546,936	2,157.7%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	48.4%	95.7%	(47.3%)			83.8%	94.3%	(10.4%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	2.6%	7.3%	4.7%			4.3%	6.5%	2.2%		

Key:
- > 0% (green)
- > -20%, < 0% (yellow)
- < -20% (red)

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@6/30/2024	2,875,867,220	2,429,246,757	446,620,463	18.4%
	Unallocated/Unassigned Reserve Balance	Current Month @ June 2024	Fiscal Year Ending June 2023	Change	%
	Consolidated	187,643,914	354,771,258	(167,127,344)	(47.1%)
	*Days Cash On Hand**	113			

*Total Designated Reserves and unallocated reserve amount can support approximatley 113 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Twelve Months Ending June 30, 2024

	June 2024				July 2023 - June 2024				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**421,169**	**1,450,696**	**1,029,527**	**71.0%**	**19,366,897**	**20,144,000**	**777,103**	**3.9%**	**22,964,948**	**56,990,000**	**34,025,052**	**59.7%**
Operating Expenses:												
Salaries, Wages & Benefits	629,198	609,654	(19,544)	(3.2%)	7,587,690	7,315,793	(271,897)	(3.7%)	11,006,267	12,608,026	1,601,759	12.7%
Professional Fees	228,137	307,924	79,787	25.9%	1,494,870	2,475,000	980,130	39.6%	1,761,063	4,707,500	2,946,437	62.6%
Purchased Services	80,959	155,000	74,041	47.8%	150,000	1,860,000	1,710,000	91.9%	150,000	2,170,000	2,020,000	93.1%
Other Expenses	876,199	1,881,007	1,004,808	53.4%	10,514,716	18,352,106	7,837,390	42.7%	13,529,492	21,644,486	8,114,994	37.5%
Total Operating Expenses	**1,814,494**	**2,953,585**	**1,139,091**	**38.6%**	**19,747,276**	**30,002,899**	**10,255,623**	**34.2%**	**26,446,822**	**41,130,012**	**14,683,190**	**35.7%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	56,990,000	22,964,948	34,025,052
FY2023 Operating Budget[2]	11,127,113	6,699,546	4,427,567
FY2024 Operating Budget	30,002,899	19,747,276	10,255,623
FY2025 Operating Budget	-	-	
Ending Funding Balance	**1,879,988**	**50,588,230**	
Add: Prior year unspent Operating Budget	**4,427,567**		
Total Available Funding	**6,307,555**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets

[2] Unspent budget from this period is added back to available DTS funding

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

Note: Report includes applicable transactions for GASB 96, Subscription.

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of June 30, 2024

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	791,124	172,137
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,675
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,089,152	3,987,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$43,960,469**	**$57,839,532**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$43,960,469**	**$17,739,532**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

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

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of June 30, 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	24,445,914	10,755,080	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,167,297	22,217,233	-
Total	**160,315,719**	**122,585,524**	**89,613,211**	**32,972,314**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	424,650	375,350	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	797,515	9,387,015	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$89,613,211**	**$32,972,314**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes as of June 30, 2024

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-24
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP	2023-24
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter	2023-24
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce iView to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract	2023-24
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards	2023-24
September	One Care	Office of Compliance - Professional Fees - CPE Audit	Office of Compliance - Professional Fees - Blue Peak Services	$20,000	To reallocate funds from Professional Fees – CPE Audit to Professional Fees – Blue Peak Services to provide funding for Blue Peak Services	2023-24
September	Medi-Cal	Customer Service - Member Communication – Maintenance of Business, Ad-Hoc/New Projects	Provider Data Mgmt. Svcs – Purchased Services	$60,000	To reallocate funds from Customer Service – Member Communication Maintenance of Business and Ad-Hoc/New Projects to Provider Data Management Services – Purchased Services to provide funding for provider directory PDF Remediation services	2023-24
September	Medi-Cal	Facilities - Audio Visual Enhancements	Facilities - CalOptima Health New Vehicle	$13,135	To reallocate funds from Facilities – Audio Visual Enhancements to Facilities – CalOptima Health New Vehicle for a new company vehicle	2023-24
September	Medi-Cal	Medical Management – Other Operating Expenses – Training & Seminar	Behavioral Health Integration – Professional Fees	$16,000	To reallocate funds from Medical Management – Other Operating Expenses – Training & Seminar to Behavioral Health Integration – Professional Fees to provide funding for Autism Spectrum Therapies	2023-24
September	Medi-Cal	Population Health Management – Purchased Services – Capacity Building Vendor	Population Health Management – Purchased Services – Capacity Building	$150,000	To repurpose funds from Purchased Services – Capacity Building Vendor to support the new Medi-Cal benefit, including incentives for contracting with CCN and delegated Health Networks, doula training, and technical assistance	2023-24
September	Medi-Cal	IS – Enterprise Data & Sys Integration – Professional Fees	Enterprise Project Management Office – Professional Fees	$75,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
September	Medi-Cal	IS – Application Development – Maintenance HW/SW	Enterprise Project Management Office – Professional Fees	$55,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
October	Medi-Cal	DTS Capital: Migrate Data Warehouse / Analytics to the Cloud	DTS Capital: Enterprise Data Quality Enhancement	$140,000	To reallocate funds from AppDev – Migrate Data Warehouse Analytics to AppDev – Enterprise Data Quality Enhancement to help with Collibra Data Governance invoice	2023-24
October	Medi-Cal	Medi-Cal/Claim - Other Operating Expenses - Food Service Supply	Medi-Cal/Claim - Other Operating Expenses - Travel	$16,000	To reallocate funds from Medi-Cal/Claim – Food Service Supply to Medi-Cal/Claim – Travel to provide funding for Center for Care Innovations	2023-24
October	Medi-Cal	Is – Infrastructure – Other Operating Expenses – Maintenance HW/SW	Provider Data Management Services – Purchased Services	$54,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
October	One Care	IS – Application Management – Maintenance HW/SW	Provider Data Management Services - Purchased Services	$24,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
November	Medi-Cal	IS - Application Management - Maintenance HW/SW	Medical Management - Professional Fees	$100,000	To reallocate funds from IS-Applications Management - Maintenance HW/SW IBM WebSphere to Medical Management - Professional Fees to fund a consulting project	2023-24
November	Medi-Cal	Executive Office - Professional Fees	Executive Office - Other Operating Expenses - Professional Dues	$28,000	To reallocate funds from Professional Fees to Professional Dues to pay for CCI Membership	2023-24
November	Medi-Cal	Infrastructure - Misc. HW/SW Technology Equipment (New Hire Equip)	Infrastructure - HW/SW Maintenance (Palo Alto Firewall)	$84,000	To reallocate funds from Infrastructure Misc. HW/SW Technology Equipment (New Hire Equipment) to HW/SW Maintenance (Palo Alto Firewall) to help with shortage of funds due to contract is co-termed	2023-24
December	Medi-Cal	505 Building - Repair & Maintenance	505 Building - Purchased Services	$228,798	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	500 Building - Repair & Maintenance	500 Building - Purchased Services	$192,120	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - F5 Network	$47,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - Calabrio	$29,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Application Mgmt. - Maintenance HW/SW (IBM WebSphere)	Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau)	$249,990	To reallocate funds from Application Mgmt. - Maintenance HW/SW (IBM WebSphere) to Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau) to help with Tableau invoice.	2023-24
December	Medi-Cal	Facilities - Comp supply/Minor Equipment	Facilities - R&M - Building	$100,000	To reallocate fund from Comp Supply/Minor Equipment to R&M - Building to address unanticipated repair costs	2023-24
December	Medi-Cal	Professional Fees - Altruista	Purchased Services - MCG	$40,000	To reallocate funds from Professional Fees - Altruista to Purchased Services - MCG to help with CMS requirement to add a link in CalOptima Health's website for Medicare members	2023-24
January	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Equipment	Delegation Oversight - Professional Fees	$96,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment to Delegation Oversight - Professional Fees to provide funding for a consultant services	2023-24
January	Medi-Cal	IS - Application Development - Professional Fees	Operations Management - Professional Fees	$150,000	To reallocate funds from Application Development – Professional Fees to Operations Management - Professional Fees to help with additional services	2023-24
January	Medi-Cal	Integrated Provider Data Management System	New Ticketing Tool for CalOptima Staff	$50,000	To reallocate funds from Integrated Provider Data Management System to New Ticketing Tool for CalOptima Staff due to shortfall of funds in Phase II	2023-24
February	Medi-Cal	IS - Infrastructure - New Hire Equipment	Executive Office - Public Activities	$17,000	To reallocate funds from Infrastructure - New Hire Equipment to Executive Office - Public Activities to provide funding to support events	2023-24
February	One Care	Customer Service - Printing and Postage - Communications	Cultural & Linguistics - Purchased Services	$50,000	To reallocate funds from Customer Service - Printing and Postage to Cultural & Linguistics - Purchased Services to supplement the anticipated gap	2023-24
February	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Grievance & Appeals - Purchased Services	$20,000	To reallocate funds from Enterprise Data & Sys Integration - Professional Fees to Grievance & Appeals - Purchased Services to provide additional funding for data scanning and storage	2023-24
February	Medi-Cal	IS-Infrastructure - Other Operating Expenses - Misc HW/SW Equipment Supplies	Provider Data Management Services - Purchased Services	$71,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment Supplies to Provider Data Management Services - Professional Fees to provide funding for provider directory PDF Remediation Services	2023-24
February	One Care	Communications - Professional Fees	Communications - Printing and Postage - Member Communication	$150,000	To reallocate funds from Communications - Professional Fees to Member Communication to provide funding needed for OneCare marketing and advertising program	2023-24
February	Medi-Cal	Infrastructure - New Hire Equipment	IS - Infrastructure - Cisco	$18,000	To reallocate funds from Infrastructure - New Hire Equipment to Infrastructure - Cisco due to shortfall of funds	2023-24
March	One Care	Quality Analytics - Professional Fees	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	One Care	Quality Analytics - Purchased Services - Stars Initiatives	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - R&M - Building	$100,000	To reallocate funds from Facilities - Office Supplies to R&M to provide funding needed for building maintenance	2023-24
March	Medi-Cal	IS - Infrastructure - Technology Equipment	IS - Infrastructure - UGovernIT	$40,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Telco Misc HW/SW	IS - Infrastructure - Palo Alto Firewall	$118,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - App Development - Provider Virtual Agent Support	IS - App Development - Migrate Website Content Management System to the Cloud	$67,100	To reallocate funds from Provider Virtual Agent Support to Migrate Website Content Management System to the Cloud due to shortfall of funds	2023-24
March	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Executive Office - Professional Fees	$28,000	To reallocate funds from IS - Enterprise & System Integration - Professional Fees to Executive Office - Professional Fees to provide funding for communications consultant	2023-24
March	Medi-Cal	IS - Cyber Security - Data Loss Prevention Suite	IS - Cyber Security - Tipping Point Intrusion Preon System	$32,000	To reallocate funds from IS - Cyber Security - Data Loss Prevention Suite to IS - Cyber Security - Tipping Point Intrusion Prevention System due to shortage of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Computer Equipment Refresh	IS - App Development - Secure Auth Web Access Management	$220,000	To reallocate funds from IS - Infrastructure - Computer Equipment Refresh to IS - App Development - Secure Auth Web Access Management due to shortage of funds	2023-24
April	Medi-Cal	IS - Applications Management - Other Operating Expenses - Maint HW/SW - Vendor Selection TBD	IS - Applications Management - Other Operating Expenses - Maint HW/SW - MCG Integrated Criteria	$20,000	To reallocate funds from IS - Applications Management - Maint HW/SW - Vendor Selection TBD to Maint HW/SW - MCG Integrated Criteria due to shortage of funds	2023-24
April	Medi-Cal	Communications - Printing and Postage - Member Communications	Communications- Purchased Services - Advertising	$25,000	To reallocate funds from Communications - Printing and Postage - Member Communications to Purchased Services - Advertising to provide additional funding for the remainder of the fiscal year	2023-24
April	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Purchased Services - Advertising	$34,000	To reallocate funds from PACE Marketing - Printing and Postage - Member Communication to Purchased Services - Advertising and Public Activities to provide additional funding for the remainder of the fiscal year	2023-24
April	OneCare	Sales & Marketing - Purchased Services - FMO and or Broker Agency Commissions and Override Fees	IS - Applications Management - Other Operating Expenses - HealthEdge Burgess Group	$150,000	To reallocate funds from the Sales & Marketing - FMO and or Broker Agency Commissions and Override Fees to IS - Applications Management - HealthEdge Burgess Group due to shortage of funds	2023-24
April	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Technology Equipment	IS - Application Development - Other Operating Expenses - Ceridian	$161,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Technology Equipment to IS - Application Development - Ceridian due to shortage of funds	2023-24
May	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Grievance & Appeals - Professional Fees	$82,000	To reallocate funds from IS - Enterprise Data & System Integration - Professional Fees to Grievance & Appeals - Professional Fees to provide funding needed for consulting service.	2023-24
May	Medi-Cal	Equity and Community Health - Printing and Postage	Equity and Community Health - Purchased Services	$130,000	To reallocate funds from Equity and Community Health - Printing and Postage to Purchased Services to provide funding for a new training module.	2023-24
May	OneCare	Customer Service - Printing and Postage - Communications	Cultural & Linguistic Services - Purchased Services - Telephonic Interpretation	$60,000	To reallocate funds Customer Service - Communications to Cultural & Linguistic Services - Telephonic Interpretation to provide additional funding needed for the remainder of the fiscal year.	2023-24
May	Medi-Cal	IS - Application Development - Other Operating Expenses - Maintenance HW/SW	Operations Management - Professional Fees - DTS Consulting Services	$230,000	To reallocate funds from IS - Application Development - Maintenance HW/SW to Operation Management - DTS Consulting Services due to shortfall of funds.	2023-24
May	OneCare	Communications - Printing and Postage - Member Communications	Communications - Professional Fees	$150,000	To reallocate funds from Communications - Member Communication to Professional Fees to provide additional funding needed for the remainder of the year.	2023-24
May	Medi-Cal	IS - Infrastructure - Other Operating Expenses - New Hire Equipment	IS - Application Development - Other Operating Expenses - Human Resource Applicant Tracking System	$92,000	To reallocate funds from IS - Infrastructure - New Hire Equipment to IS - Application Development - Human Resource Applicant Tracking System due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Professional Fees - IT Service Management	IS - Infrastructure - Other Operating Expenses - HDI Training & Seminars	$23,000	To reallocate funds from IS - Infrastructure - IT Service Management to IS - Infrastructure - HDI Training & Seminars due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Professional Fees - IT Service Management	IS - Infrastructure - Other Operating Expenses - Azure Training & Seminars	$25,000	To reallocate funds from IS - Infrastructure - IT Service Management to IS - Infrastructure - Azure Training & Seminars due to shortage of funds.	2023-24
May	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Subscriptions	Customer Service - Purchased Services	$100,000	To reallocate funds from ITS - Infrastructure - Subscriptions to Customer Service - Purchased Services to provide additional funding to pay for Centauri invoices for the remainder of the fiscal year.	2023-24
June	Medi-Cal	IS - Instrastructure - Other Operating Expenses - Subscriptions	Customer Service - Member Communication	$120,000	To reallocate funds from ITS-Infrastructure - Subscriptions to Customer Service – Member Communication to provide additional funding to pay for Printing for the remainder of the fiscal year.	2023-24
June	Medi-Cal	Medical Management - Other Operating Expenses - Professional Dues	Medical Management - Other Operating Expenses - Training & Seminars	$30,000	To reallocate funds from Medical Management - Professional Dues to Training & Seminars to provide funding needed for the overage in the account and for The Innovative Health Care Leader course.	2023-24
June	Medi-Cal	Communications - Printing and Postage - Member Communications	Communications - Purchased Services - General	$12,000	To reallocate funds from Member Communication to Purchased Services to provide additional funding for purchasing image credits for the remainder of the fiscal year.	2023-24
June	Medi-Cal	Routine Capital - Audio Visual Enhancements	Routine Capital - Furniture Upgrades	$71,000	To reallocate from capital project – Audio Visual Enhancements to capital project – Furniture Upgrades provide funding for additional furniture purchases	2023-24
June	Medi-Cal	Human Resources - Professional Fees	Human Resources - Advertising	$25,000	To reallocate funds from Professional Fees – Executive Recruiters to Advertising to provide additional funding for job postings.	2023-24
June	Medi-Cal	Routine Capital - Technology Updates	Routine Capital - Tenant Improvements	$200,000	To reallocate from capital project – Technology Updates to capital project – Tenant Improvements to provide funding for change orders	2023-24

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

Board of Directors Meeting
August 1, 2024

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. Medicare

- **Calendar Year (CY) 2022 Centers for Medicare & Medicaid Services (CMS) 1/3 Financial Audit *(applicable to OneCare)*:**

  Update:
  - ➢ The Agree/Disagree Letter was shared with CalOptima Health, which included three findings and one observation.
    - ▪ CalOptima Health provided a response back to the auditor on June 4, 2024.
  - ➢ CalOptima Health is pending the Final Report from the auditor.
  - ➢ CalOptima Health Compliance has initiated the CAP process for the findings noted.

  Background:
  - ➢ At least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid.
  - ➢ CMS notified CalOptima Health that its OneCare plan had been selected for the CY2022 CMS Financial Audit and Davis Farr LLP will conduct the audit. Davis Farr LLP acted in the capacity of CMS agents and requested records and supporting documentation for, but not limited to, the following items:
    - ▪ Claims data
    - ▪ Solvency
    - ▪ Enrollment
    - ▪ Base year entries on the bids
    - ▪ Medical and/or drug expenses
    - ▪ Related party transactions
    - ▪ General administrative expenses
    - ▪ Direct and Indirect Remuneration (DIR)

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- **<u>2024 Medicare Part C and Part D Data Validation Audit (MDVA) (*applicable to OneCare*)</u>:**

  <u>Update</u>:
  - ➢ CalOptima Health has contracted with an independent consulting firm to conduct its annual MDVA audit as required by Medicare Advantage and Part D (MAPD) regulations.
  - ➢ The consulting firm finalized the 2024 Medicare Data Validation Audit scores in Health Plan Management System (HPMS).
  - ➢ Scores are 99% for Part C and 100% for Part D for OneCare (OC).
  - ➢ The Closing Conference will be scheduled in July.

- **<u>2024 CMS Program/Focused Audit Readiness *(applicable to OneCare)*</u>*:***

  <u>Update:</u>
  - ➢ CalOptima Health engaged an external auditor to conduct a mock audit for readiness for a CMS Utilization Management (UM) Focused audit.
  - ➢ The Final Audit Findings report was received on June 28, 2024.
    - ▪ There are a total of 2 observations, 6 observations requiring corrective action (ORCA), 4 corrective actions required (CAR), and 1 immediate corrective action required (ICAR).
  - ➢ CalOptima Health Compliance is currently prepping all corrective action plans as a result of the audit findings noted.
  - ➢ Executive Discussion with the external auditor to address all findings and next steps was held July 15, 2024.

  <u>Background:</u>
  - ➢ On October 24, 2023, CMS announced it is adding a new UM focused audit, which is limited to ODAG (Organization Determinations Appeals and Grievances) and CPE (Compliance Program Effectiveness) for Plans who do not have 2024 routine scheduled program audits.
  - ➢ This new focused audit is designed to specifically target compliance with the coverage and Utilization Management (UM) policies finalized in CMS-4201-F, which was effective January 1, 2024.
  - ➢ CalOptima Health Compliance has confirmed implementation of new requirements from CMS-4201-F.
  - ➢ CalOptima Health anticipates receiving a targeted audit engagement letter between January through July 2024.

2. Medi-Cal

- **<u>2024 Department of Health Care Services (DHCS) Routine Medical Audit</u>:**

  ***<u>Update</u>**:*
  - ➢ As of July 8, 2024, CalOptima Health continues to wait for its draft audit report.

  ***<u>Background</u>**:*
  - ➢ March 29, 2024, DHCS held its close-out meeting with the Office of Compliance

        - Close-out meeting marked the conclusion of the 2-week interview period (March 18, 2024, through March 29, 2024).
        - DHCS clarified that it continued to review and assess CalOptima Health; no findings or observations were formally shared with CalOptima Health.
    - CalOptima Health is awaiting its draft audit report, which should be provided any time now.
    - Below is the anticipated timeline provided by DHCS; please be advised these timeframes are subject to change.
    - DHCS will provide its Draft Findings & host an Exit Conference (via webinar).
        - 3 business days prior to Exit Conference: Draft findings will be provided to CalOptima Health for review.
        - Post Exit Conference:
            - CalOptima Health will have 15 calendar days from the Exit Conference to review Draft Findings and provide comments/rebuttal.
            - DHCS will then have an additional 15 calendar days to review CalOptima Health's comments/rebuttals.
        - 30 calendar days post the Exit Conference, CalOptima Health will receive the final audit report and its formal request for corrective action.
        - CalOptima Health must submit its response to the corrective action, 30 calendar days from receipt of the request.
        - CalOptima Health must ensure that all corrective actions are complete and effectuated within 180 calendar days of the formal corrective action plan (CAP) response.

- **2023 DHCS Routine Medical Audit (Focused Scope):**

    Update:

    - On 6/19/24, CalOptima Health received the draft findings report for the Transportation and Behavioral Health focused audit conducted by DHCS in early 2023.
    - The draft report includes **2 findings** in the area of Behavioral Health. There were no findings for Transportation services.
        - CalOptima Health submitted its response to DHCS on Tuesday, July 9, 2024, and did not dispute the contents of the draft report.
        - Next, DHCS is expected to finalize its draft report and provide CalOptima Health with a final report and formal request for corrective action.
    - CalOptima Health has commenced work internally to remediate the findings.

    Background:

    - In 2022, DHCS notified all Medi-Cal managed care health plans (MCPs) that it would be conducting focused audits to assess performance in certain identified high-risk areas. DHCS scheduled these focused audits concurrently with the routine annual medical audit. CalOptima Health's annual audit was conducted in February-March 2023 and the corresponding CAP was closed on 12/29/23; however, findings for the *focused audit* were not issued until 6/19/24.
    - The focused audit differs from DHCS' regular annual medical audit in scope and depth. The annual medical audit evaluates the MCPs organizational structures, policies and procedures, and systems for compliance with contractual requirements. The focused audit examines the operational issues that may hinder appropriate and timely members' access to medically necessary care. As part of the focused audit, DHCS reviewed

supporting documents, conducted interviews with CalOptima Health staff, and evaluated file samples.

Below are key highlights:

- Audit Type: Focused
- **Transportation**
  - Non-Emergency Medical Transportation (NEMT)
  - Non-Medical Transportation (NMT)
- **Behavioral Health**
  - Specialty Mental Health Services (SMHS)
  - Non-Specialty Mental Health Services (NSMHS)
  - Substance Use Disorder Services (SUDS)
- LOB: Medi-Cal
- Audit Period: 2/1/22-1/31/23
- Dates of Audit: 2/27/23-3/10/23

- **California State Audit (CSA):**

Update:

- As of July 8, 2024, CalOptima Health awaits a response from CSA to its 1-year response.

Background:

- As directed by the Joint Legislative Audit Committee, the California State Auditor (CSA) conducted an audit of certain aspects of CalOptima Health's budget, services and programs, and organizational changes.
- On May 2, 2023, the CSA released a report following a comprehensive nine-month audit of CalOptima Health that covered an eight-year period from January 2014 through June 2022.
- In response to the seven (7) recommendations made by CSA, CalOptima Health is required to submit 60-day, 6-month and 1-year status update regarding the implementation of each recommendation.
  - CalOptima Health's 60-day update to CSA was submitted June 30, 2023
  - CalOptima Health's 6-month update was submitted on November 2, 2023
  - CalOptima Health's 1-year update was submitted to CSA on May 2, 2024
- CSA will use the information provided by CalOptima Health to determine whether a follow-up audit is necessary.
  - CSA may also use the information to update policy and fiscal committees and subcommittees about the implementation status of all State Auditor recommendations to facilitate legislative oversight of audited agencies.
- On May 2, 2024, CalOptima Health submitted its required 1-year update to the CSA.
- CalOptima Health provided narrative responses and supporting documentation on the remaining four of the seven initial recommendations.
  - CalOptima Health sent a follow-up communication to CSA subsequent to the May 2, 2024, CalOptima Health Board of Directors meeting indicating all four remaining items were "Fully Implemented".
- CalOptima Health awaits CSA's feedback and will continue to track this audit to closure.

B. Regulatory Notices of Non-Compliance

- On June 3, 2024, CMS issued a compliance notice to CalOptima Health for Contract H5433 (OneCare) for failure to meet call center requirements for disconnect rates. The passing disconnect rate is ≤ 5%. The Part C and D disconnect percentage rate for CalOptima Health was 5.36%.
- The Corrective Action Plan (CAP) for this deficiency had already been processed with the Customer Service team at the time the official compliance notice was received from CMS.
  - The CAP was accepted with successful monitoring and closed on May 31, 2024.

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits**:

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
    - CHOC Health Alliance (20) – May 1, 2023 - March 31, 2024
  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO issued a corrective action plan (CAP) request, and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Internal Audit Updates

- **Internal Audits**:

  - The following annual audits have concluded:
    - Coverage Determinations, Appeals and Grievances (CDAG) Pharmacy and Grievances, Appeals and Resolutions (GARS) Grievance Part D (OneCare) Annual Audit
      - CAP accepted and closed on May 9, 2024. Presented to the Compliance Committee on May 21, 2024.
    - Grievance and Appeals (Medi-Cal) Annual Audit
      - CAP accepted and closed on July 3, 2024. To be presented to the Compliance Committee at the next meeting.
    - PACE Annual Audit
      - CAP accepted and closed on June 18, 2024. To be presented to the Compliance Committee at the next meeting.
    - Utilization Management (Medi-Cal) Annual Audit
      - CAP accepted and closed on January 19, 2024. Presented to Compliance Committee on May 21, 2024.
    - Utilization Management (OneCare) Annual Audit

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    - CAP accepted and closed on May 21, 2024. Presented to Compliance Committee on May 21, 2024.

- The following annual audits are currently in progress:
  - Customer Service (OneCare) Annual Audit
    - Webinar commenced and concluded on July 1, 2024
  - Customer Service (Medi-Cal) Annual Audit
    - Webinar will commence on August 5, 2024

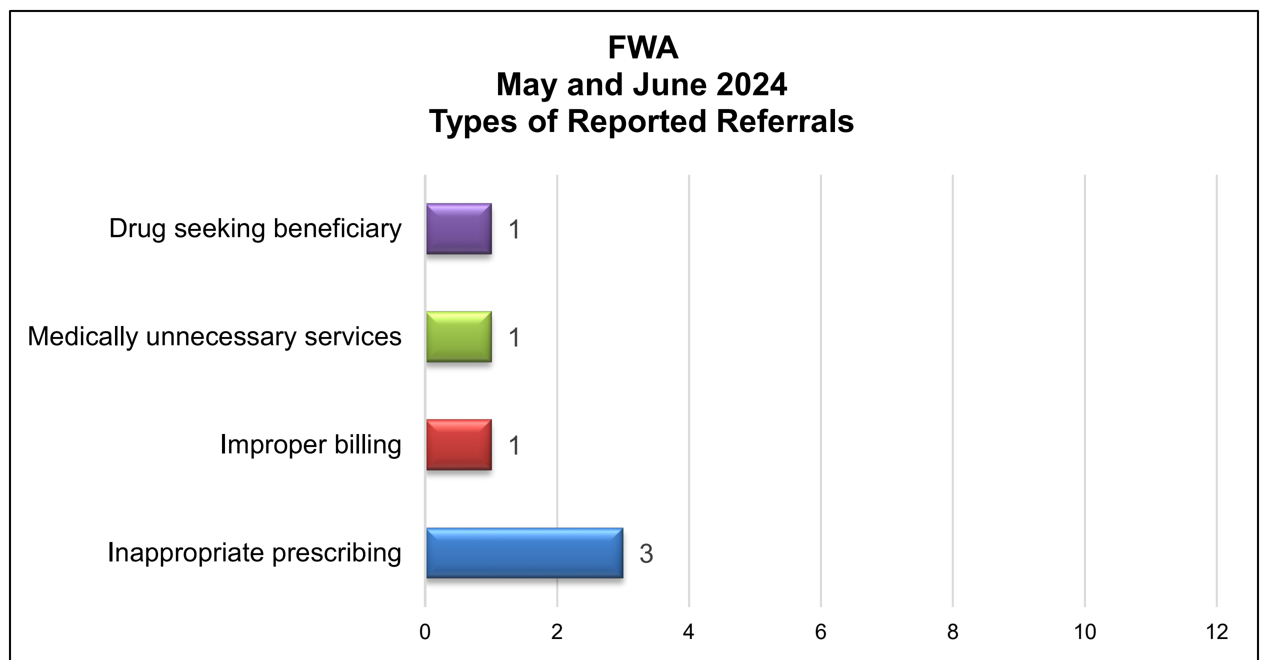
- The following are in Ad-hoc review (Internal CAP Request)
  - FWA Privacy
    - CAP accepted and closed on July 12, 2024. To be presented to the Compliance Committee at the next meeting.
  - Claims
    - CAP accepted and closed on July 12, 2024. To be presented to the Compliance Committee at the next meeting.

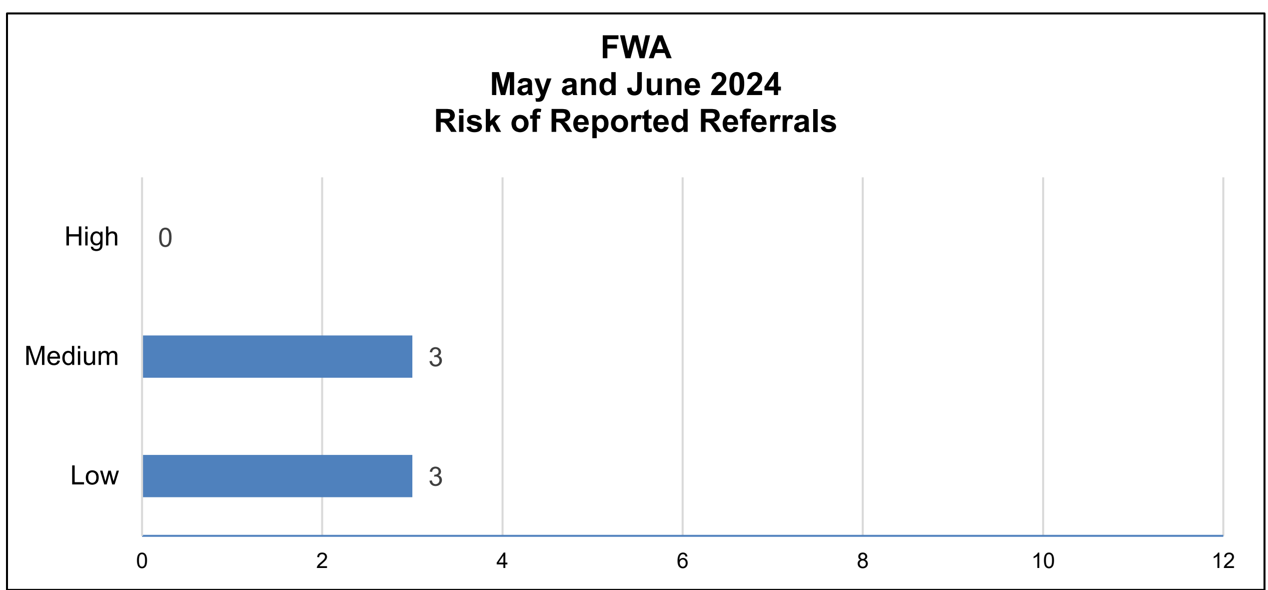
- **Board-Approved Initiatives Review:**

  Update:
  - Implementation of consultant's recommendations have started with development of the Grants Policy and Playbook.
  - Consultant is in the process of performing close out reviews for two completed grants.

  Background:
  - CalOptima Health's Internal Audit department is currently in the process of reviewing CalOptima Health's Board-approved initiatives. Internal Audit's goal is to identify opportunities to strengthen the oversight of the fund's surplus expenditure management process, including the structure for reviewing and signing off on grant programs and initiatives.
  - There are 26 Board-approved initiatives with total funding allocations of approximately $922 million. Initiatives are classified into the following program types:
    - Grant programs
    - Quality/Population Health Management programs
    - Strategic Initiatives

E. Fraud, Waste & Abuse (FWA) Investigations (May and June 2024)





Total Number of New Cases Referred to DHCS (State)	6
Total Number of New Cases Referred to DHCS and CMS*	4
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**6**

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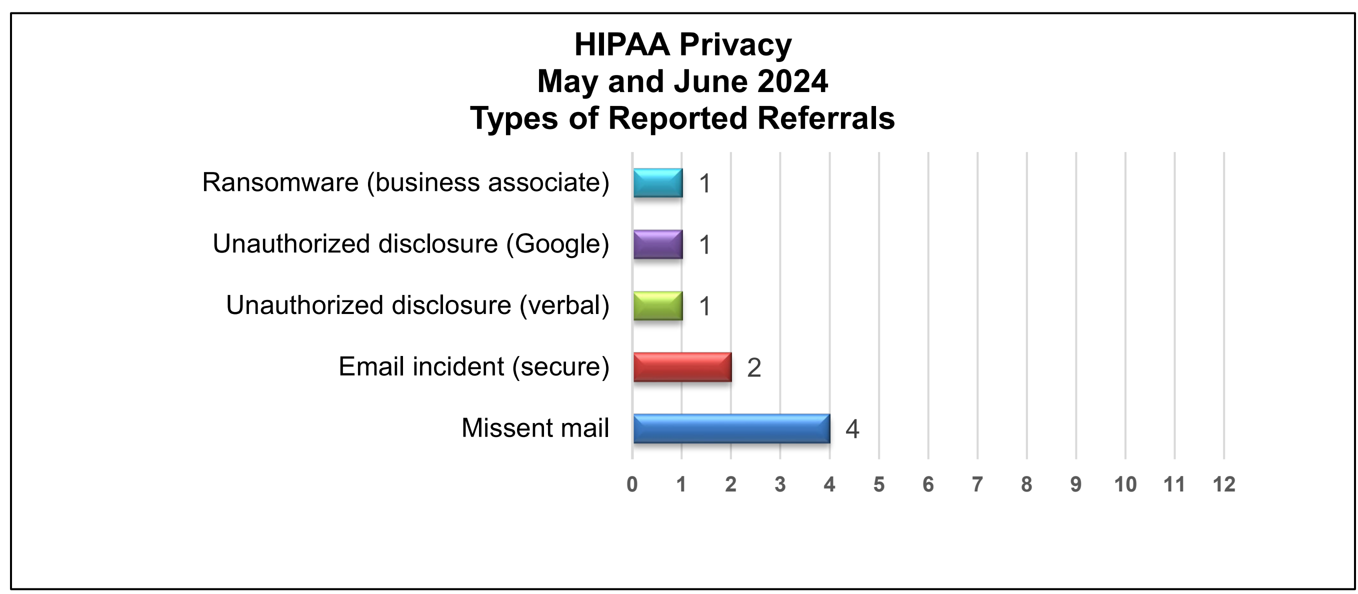
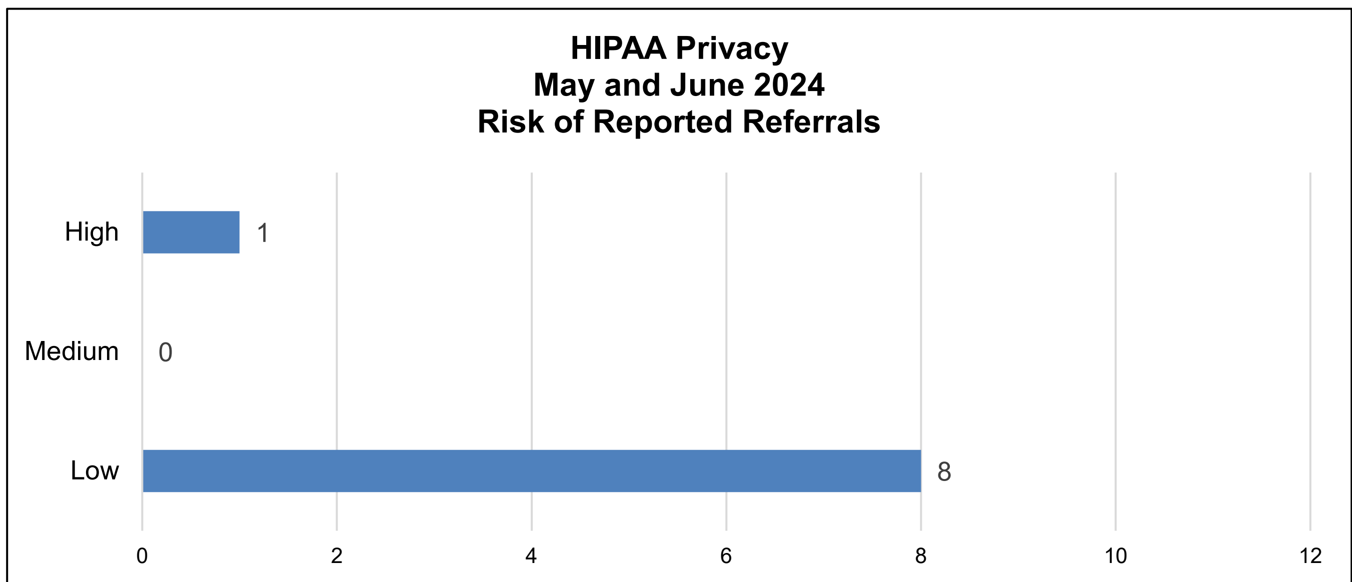
F. <u>Privacy Update</u> (May and June 2024)





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

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MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: July 24, 2024

SUBJECT: August Board of Directors Report

CalOptima Health, Chamber Hill Strategies Meet with Congressional Delegation, Advocate for Behavioral Health Workforce Request

Jordan Abushawish, CalOptima Health's Senior Director of Federal and Local Government Affairs, traveled to Washington, D.C. to attend meetings on July 17 and 18 with the Chamber Hill Strategies team on Capitol Hill. The purposes of the meetings were twofold: 1) First, the meetings provided the opportunity to introduce Chamber Hill Strategies as CalOptima Health's new federal affairs consultants to California's senators and the Orange County delegation to Congress; 2) Second, the meetings provided the opportunity to advocate for support of Senator Laphonza Butler's request for $5 million for CalOptima Health's Safety Net Behavioral Health Workforce Development Program. Shawn Friesen, Principal, Chamber Hill Strategies, and Stacey Rampy, Principal, Chamber Hill Strategies coordinated in planning the itinerary and joined Jordan for in-person meetings on Capitol Hill, which included staff to Senator Butler (D-CA), Senator Alex Padilla (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), Rep. Michelle Steel (R-CA-45), Rep. Katie Porter (D-CA-47), and Rep. Linda Sanchez (D-CA-38). Jordan and Shawn met virtually with staff to Rep. Mike Levin (D-CA-49) on July 23 as Rep. Levin's Washington staff were out of the office on July 17 and 18. In addition to meeting with the Orange County delegation, Chamber Hill Strategies arranged a meeting with staff to Rep. Ken Calvert (R-CA-41) to educate his staff regarding CalOptima Health and highlight CalOptima Health's appropriations request. Chamber Hill Strategies wanted to highlight the request for Rep. Calvert as he is the most senior California member on House Appropriations Committee. In addition, while Rep. Calvert does not presently represent Orange County, he has represented parts of Orange County in the past and California's 41st congressional district, which he represents, borders Orange County and could be impacted by the project.

Reps. Correa and Kim Lead Letter of Support for Behavioral Health Workforce Request

Rep. Lou Correa (D-CA-46) and Rep. Young Kim (R-CA-40) partnered to lead a bipartisan July 23 letter to Senator Laphonza Butler (D-CA) expressing thanks and support for her requesting $5 million for CalOptima Health's Safety Net Behavioral Health Workforce Development Program. Chamber Hill Strategies and CalOptima Health team members partnered together to successfully secure support from Reps. Correa, Kim, Steel, Sanchez and Levin. (Note: Rep. Porter's office has a policy against signing appropriations request letters.) In addition to Rep. Correa's staff sending the letter to Sen. Butler's office, Chamber Hill

Strategies staff shared the letter with key staff on the Senate Appropriations Subcommittee on Labor, Health & Human Services, Education, and Related Agencies, which has jurisdiction over the request.

Congressional Outlook for Health Legislation

The House of Representatives canceled votes that had been previously scheduled for the week of July 29, meaning that the House broke for August recess without considering several health-related bills and issues that must be addressed before year's end. Among the issues expected to be addressed later this year are telehealth flexibilities that are scheduled to expire in December 2024 as well as legislation designed to reign in and bring more transparency to the practices of pharmacy benefit managers.

By breaking a week earlier than previously scheduled, it also meant that the House has yet to address several appropriations bills to fund the government for Fiscal Year 2025 (FY2025). Funding for FY2024 expires on September 30. Among the appropriations bills still awaiting House consideration is the bill to fund the Departments of Labor, Health & Human Services, Education, and Related Agencies (Labor-HHS). As of this writing, it was rumored that the Senate Appropriations Committee was aiming to consider the Senate version of the Labor-HHS bill the week of July 29, but the Committee had yet to notice the meeting. Regardless of any Committee or floor activity in September, it is expected that Congress will need to approve legislation, referred to as a continuing resolution, to continue funding many government programs for FY2025, including Labor-HHS, at FY2024 levels by September 30. (Note: Continuing resolutions do not include requests such as CalOptima Health's Safety Net Behavioral Workforce Development Program.)

After August, there are only three legislative weeks remaining for Congress to consider legislation prior to the election. While the House or Senate may consider and move a handful of noncontroversial health-related bills in September, it is widely expected that Congress will not move any significant health-related bills, including telehealth and PBM legislation, until after the election.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
July 16, 2024

General Update

There were a few key legislative deadlines in the last month. June 15 was the deadline for the legislature to pass a budget, giving the Governor time to sign the budget into law before the new fiscal year began on July 1. More budget details are outlined below.

June 27 was a key deadline to remove measures from the November ballot. Some key initiatives were marked by intense last-minute initiative negotiations. The courts took the "Taxpayer Protection Act" initiative, pursued by the California Business Roundtable, off the ballot. It would have required voter approval for statewide taxes passed by the Legislature. Agreeing with the Administration, the unanimous court decision stated it amounted to a constitutional revision rather than an amendment, altering the basic structure of state government.

The tough-on-crime measure to reform 2014's Proposition 47, sponsored by retailers and the District Attorney's Association, will remain on the ballot as Proposition 36, despite the efforts of the Governor to persuade the proponents to remove the initiative in favor of a legislative package previously proposed to deal with retail theft. The Governor's desire to make the legislative package inoperable if the initiative passes caused several legislative authors to threaten withdrawal of their bills. The Governor was also unable to pull together a competing initiative to Proposition 36 that would have countered its more punitive approach.

July 3 was also a key policy deadline for bills. All bills needed to be approved by the opposite house's policy committees as of this date. All remaining bills now move on to the fiscal committees of the opposite house. The legislature adjourned for summer recess on July 3 and will reconvene August 5.

The next key bill deadline will take place on August 15, when the Appropriations Committees will release the "suspense file" on bills sent to them by the other house (which tends not to be as accommodating as the legislators' own house).

Budget Update

On June 13, both houses of the Legislature passed AB 107, the Budget Act of 2024, along with two other budget-related bills, beating the legislative deadline by two days. The Governor signed the budget on June 26 just in time for the July 1 fiscal year to begin. The Governor approved other budget bills on July 2 and is expected to request additional "clean-up" budget legislation in August.

Managed Care Organization (MCO) Tax – The legislature pushed back on the Governor's May Revision's surprise sweep of all the MCO tax revenue to the General Fund. While the final budget restored many Medi-Cal provider rate increases from the original agreement with the MCO Tax Coalition agreement from last year, there are still significant changes. The investments are decreased, partially redistributed, delayed to 2025 or 2026, and additional provider types will receive a portion of the monies (reducing the overall funding of the original provider types).

Several provisions of the final budget's MCO tax agreement will become inoperable if voters approve the related MCO Tax Initiative (Proposition 35) on the November 5th ballot.

Health Care Worker $25/Hour Minimum Wage Increase – Under the budget agreement, the minimum wage increase for health care workers will be implemented once one of the following occurs: 1) the state determines that, in the first quarter of the fiscal year, cash receipts are 3% higher than what was projected at the time of budget passage; or 2) when DHCS notifies the Joint Legislative Budget Committee that it is seeking CMS approval to increase hospital quality assurance fees to support more revenue for Medi-Cal to offset costs. The wage increase is estimated to be implemented no earlier than October 1, 2024, and no later than January 1, 2025.

Key Legislation Update

SB 516 (Skinner): Prior Authorization -– Last year, Senator Nancy Skinner (D-Oakland) pursued this legislation through the "gut and amend" process. This bill seeks to control health insurance plans' use of prior authorization, by waiving it for clinicians who have 90% of their prior authorizations approved. The bill remains alive but has had no action or hearings so far this year.

SB 1120 (Becker): Utilization Review for Health Care -– Sponsored by doctors, this bill mandates that health plans using AI for utilization review have a licensed physician supervise all AI decision-making tools. Since AI has helped expedite approvals for authorizations, some health plans are concerned the language could slow the authorization process. The bill has cleared the Senate and met the July 3 policy deadline of the Assembly. It is now awaiting action in the Assembly Appropriations Committee.

Propositions and Initiatives

Proposition 1: Behavioral Health Transformation (BHT) – Approved by voters in March, this is an overhaul of California's mental health funding system and a $6.4 billion bond for facilities. The Governor announced that the first round of bond funding ($3.3 billion) will be available through project solicitations in July. Counties, cities, tribes, non-profits, and for-profits are eligible to apply. County mental health departments must support the proposed projects and matching funds/collateral are required. DHCS has set up a "Self-Guided Module" for general Behavioral Health Continuum Infrastructure Program (BHCIP) match requirements that provides the latest update.

Proposition 35: "Protect Access to Health Care Act of 2024" (MCO Tax) – Funded by a broad coalition of providers and other groups, the initiative has qualified for the November 2024 ballot, despite efforts by the Governor to have the initiative pulled by the June 27 deadline. Passage of this initiative would be the first time this tax, which leverages federal reimbursement dollars, is made a permanent tax on health plans. This has proven particularly important given the recent proposed sweep by the Administration of the MCO tax to help solve the budget deficit and the resulting pushback by the legislature. The MCO Tax deal in the current budget will become inoperable should Proposition 35 succeed. The campaign in support has raised over $8 million.

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2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 3430 Wyden (OR) Crapo (ID)	**Better Mental Health Care, Lower-Cost Drugs, and Extenders Act:** Would expand access to behavioral health services, reduce prescription drugs costs through pharmacy benefit manager (PBM) reforms and extend certain expiring provisions of the Medicare and Medicaid programs. Specific notable elements include but are not limited to the following: • Increasing all Medicare physician fee schedule payments by 2.5% (rather than 1.25%) for 2024 services. • Increasing Medicare physician fee schedule payments for certain behavioral health integration services in primary care settings during 2026–28. • Increasing Medicare bonus payments to providers that furnish mental health and substance use disorder (SUD) services in health professional shortage areas; expanding such bonus payments to include non-physician health care professionals. • Expanding access to behavioral telehealth services across state lines and for those with limited English proficiency. • Medicaid funding of up to seven days for services delivered to incarcerated individuals diagnosed with an SUD and pending disposition of charges. • Eliminating cuts to Medicaid disproportionate share hospital payments through September 30, 2025. Additionally, would include provisions from S. 3059, the Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act, to require accurate provider directories on public websites updated every 90 days. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of CalOptima Health's OneCare provider directory.	**12/07/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and SUD services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact****:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or SUD treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**01/19/2024** Died in Assembly Appropriations Committee **03/14/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition — regardless of duration and whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**06/24/2024** Re-referred to Senate floor **06/12/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **01/25/2024** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/12/2023** Passed Senate floor; referred to Assembly for concurrence in amendments **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1936 Cervantes	**Maternal Mental Health Screenings:** Would require a health plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy and at least one additional screening during the first six months of the postpartum period, if determined medically necessary and clinically appropriate, to improve treatment and referrals to other maternal mental health services, including coverage for doulas. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal benefit for CalOptima Health Medi-Cal members.	**06/20/2024** Passed Senate floor; referred to Assembly for concurrence in amendments **05/09/2024** Passed Assembly floor	CalOptima Health: Watch
AB 2556 Jackson	**Behavioral Health and Wellness Screenings Notice:** Would require a health plan, on an annual basis, to provide each legal guardian of an enrollee ages 10 to 18 a written or electronic notice regarding the benefits of a behavioral health and wellness screening. ***Potential CalOptima Health Impact***: Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/20/2024** Passed Senate floor; referred to Assembly for concurrence in amendments **05/02/2024** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
Budget			
H.R. 2872 Graves (LA)	**Further Additional Continuing Appropriations and Other Extensions Act, 2024:** Enacts a third Continuing Resolution (CR) to further extend Fiscal Year (FY) 2023 federal spending levels from January 19, 2024, through March 1, 2024, for certain agencies, and from February 2, 2024, through March 8, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**01/19/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2882 Ciscomani (AZ)	**Further Consolidated Appropriations Act, 2024:** Enacts the remaining six FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $1.2 trillion through September 30, 2024: • Department of Defense Appropriations Act, 2024 • Financial Services and General Government Appropriations Act, 2024 • Department of Homeland Security Appropriations Act, 2024 • Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2024 • Legislative Branch Appropriations Act, 2024 • Department of State, Foreign Operations, and Related Programs Appropriations Act, 2024 Of note, funding for the U.S. Department of Health and Human Services (HHS) remains relatively flat with only a 1% increase compared to FY 2023. However, approximately $4.3 billion in unspent COVID-19 relief funding is rescinded. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/23/2024** Signed into law	CalOptima Health: Watch
H.R. 4366 Carter (TX)	**Consolidated Appropriations Act, 2024:** Enacts six of the 12 regular FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $459 billion through September 30, 2024: • Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2024 • Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2024 • Commerce, Justice, Science, and Related Agencies Appropriations Act, 2024 • Energy and Water Development and Related Agencies Appropriations Act, 2024; • Department of the Interior, Environment, and Related Agencies Appropriations Act, 2024 • Transportation, Housing and Urban Development, and Related Agencies Appropriations Act, 2024 In addition, extends several expiring programs and authorities, including several public health programs. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/09/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7463 Granger (TX)	**Extension of Continuing Appropriations and Other Matters Act, 2024:** Enacts a fourth CR to further extend FY 2023 federal spending levels from March 1, 2024, through March 8, 2024, for federal agencies through March 8, 2024, and through March 22, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**03/01/2024** Signed into law	CalOptima Health: Watch
SB 136 Committee on Budget and Fiscal Review	**Managed Care Organization (MCO) Provider Tax Amendment Trailer Bill I:** Subject to approval by the Centers for Medicare and Medicaid Services (CMS), increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II to $205 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health to be reimbursed at an approximately equivalent amount; increased funding for Medi-Cal programs and provider rates.	**03/25/2024** Signed into law	CalOptima Health: Watch
SB 159 Committee on Budget and Fiscal Review	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2024-25 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
AB 106 Gabriel	**Budget Acts of 2022 and 2023:** Amends the Budget Act of 2022 and the Budget Act of 2023 to support appropriations for FYs 2023–24 as part of the early action agreement that includes a combination of $3.6 billion in reductions (primarily to one-time funding), $5.2 billion in revenue and borrowing, $5.2 billion in delays and deferrals, and $3.4 billion in shifts of costs from the General Fund to other state funds. Significant health care provisions include the following: • Behavioral Health Continuum Infrastructure Program: $140.4 million delay • Behavioral Health Bridge Housing: $235 million delay • MCO Provider Tax: $3.8 billion in revenue borrowing ***Potential CalOptima Health Impact*:** Adjusted but broadly sustained funding for behavioral health programs impacting CalOptima Health members.	**04/03/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 107 Gabriel **SB 108** Wiener	**Budget Act of 2024:** Makes appropriations for the government of the State of California for FY 2024–25. Total spending is $293 billion, of which $211.5 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**6/29/2024** Signed into law	CalOptima Health: Watch
AB 160 Committee on Budget	**MCO Provider Tax Amendment Trailer Bill II:** Subject to approval by CMS, further increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II from $205 to $274 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a Medi-Cal Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**01/19/2024** Died in Assembly Appropriations Committee **04/11/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Medi-Cal Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**01/19/2024** Died in Assembly Appropriations Committee **04/18/2023** Passed Assembly Health Committee	CalOptima Health: Watch
Covered Benefits			
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Increases Medi-Cal coverage of PrEP and PEP furnished by a *pharmacist* from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**02/06/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 953 Menjivar	**Menstrual Products:** Would add menstrual products as covered Medi-Cal benefits. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Senate Appropriations Committee **03/20/2024** Passed Senate Health Committee	CalOptima Health: Watch
SB 1180 Ashby	**Emergency Medical Services:** Would require health plans to cover services provided by a community paramedicine program, triage to alternate destination program and mobile integrated health program. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**06/18/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/21/2024** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
AB 47 Boerner	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**08/21/2023** Re-referred to Senate floor **06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1975 **(AB 1644)** Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**06/12/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor **01/30/2024** Re-introduced as AB 1975 **01/19/2024** Died in Assembly Appropriations Committee as AB 1644	CalOptima Health: Watch LHPC: Support CAHP: Support
AB 2105 **(AB 907)** Lowenthal	**PANDAS and PANS**: Beginning January 1, 2025, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), prescribed or ordered by a provider as medically necessary. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**06/24/2024** Passed Senate Appropriations Committee; referred to Senate floor **05/21/2024** Passed Assembly floor **02/05/2024** Re-introduced as AB 2105 **10/07/2023** Vetoed as AB 907 *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2446 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals: • Infants or toddlers with certain conditions such as urinary tract infection and diseases of the skin. • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to EPSDT standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**06/26/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch
AB 2668 Berman	**Cranial Prostheses:** Beginning January 1, 2025, would add cranial prostheses as a covered Medi-Cal benefit as part of a prescribed course of treatment for individuals experiencing permanent or temporary medical hair loss. Coverage would be limited to a maximum of $750 for each instance, no more than once per year. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 2843 Petrie-Norris	**Rape and Sexual Assault Care:** Would require a health plan to provide coverage without cost-sharing for emergency room medical care and follow-up treatment following a rape or sexual assault. Would also prohibit a health plan from requiring members to provide a police report or press charges for rape or sexual assault in order to receive care. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**07/03/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/16/2024** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
SB 1112 Menjivar	**Families with Subsidized Childcare:** Would require DHCS and the California Department of Social Services (CDSS) to inform and direct families receiving subsidized childcare on how to enroll an eligible child into Medi-Cal. Additionally, the child would be referred to developmental screenings that are available under EPSDT services. ***Potential CalOptima Health Impact*:** Expanded procedures for enrollment of pediatric CalOptima Health members.	**06/25/2024** Passed Assembly Human Services Committee; referred to Assembly Appropriations Committee **06/11/2024** Passed Assembly Health Committee **05/24/2024** Passed Senate floor	CalOptima Health: Watch
SB 1289 Roth	**Medi-Cal Call Center Standards and Data:** Would require DHCS to establish, with stakeholder input, statewide minimum standards for assistance provided by a county's call centers to individuals applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage ***Potential CalOptima Health Impact:*** Increased resources for CalOptima Health members; increased number of CalOptima Health members as a result of additional new enrollments and fewer disenrollments.	**06/04/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/21/2024** Passed Senate floor	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1783 Essayli	**Unsatisfactory Immigration Status:** States the intent of the Legislature to enact legislation to prohibit state funding of health care benefits for individuals with unsatisfactory immigration status. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members	**01/04/2024** Introduced	CalOptima Health: Watch
AB 2956 Boerner	**Adult Continuous Eligibility and Redetermination:** Would require DHCS to seek federal approval to extend continuous Medi-Cal eligibility to individuals over 19 years of age. Would also require a county to attempt communication through all additional available channels before completing a redetermination and to conduct an additional review of information in an attempt to renew eligibility without needing a response., Would require counties to accept self-attested information from beneficiary for the purpose of income verification during a redetermination. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment and re-enrollment of CalOptima Health members.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. HHS estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1120 Becker	**Artificial Intelligence (AI) in Utilization Review:** Would require a health plan's use of algorithms, AI, and other software tools for utilization management purposes to comply with specified fairness and equity requirements. ***Potential CalOptima Health Impact:*** Implementation of new utilization management (UM) procedures	**07/02/2024** Passed Assembly Privacy and Consumer Protection Committee; referred to Assembly Appropriations Committee **06/18/2024** Passed Assembly Health Committee **05/23/2024** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose unless amended
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2200 Kalra	**Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of California. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 2340 Bonta	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Informational Materials:** Would require DHCS to standardize informational materials that effectively explain and clarify the scope and nature of EPSDT services that are available under the Medi-Cal program, including content designed for youth. Would require a Medi-Cal MCP to provide the informational materials to EPSDT-eligible beneficiaries and their parents within 60 days of initial Medi-Cal eligibility determination and annually thereafter. ***Potential CalOptima Health Impact:*** Standardization and increased number of mailings to certain CalOptima Health Medi-Cal members.	**06/24/2024** Re-referred to Senate floor **06/12/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/16/2024** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2466 Carrillo	**Network Adequacy Standards:** Would deem a Medi-Cal MCP out of compliance with appointment time standards if either of the following are true: • Fewer than 85% of network providers had an appointment available within the standards • DHCS receives information establishing that the plan was unable to deliver timely, available or accessible health care services Would also require health plans to submit an annual renewal request for alternative access standards, describing the efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 3260 Pellerin	**Utilization Reviews and Grievances:** Would require health plans to complete utilization review decisions within 72 hours. If a plan fails to meet such deadline, the plan must automatically open a grievance on behalf of the affected beneficiary. Additionally, would require plans to review urgent grievances, as determined by the provider, within 72 hours. ***Potential CalOptima Health Impact***: Expedited and modified UM and Grievance procedures for covered Medi-Cal benefits.	**06/26/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the CMS for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
S. 3950 Cassidy (LA)	**Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024:** Would require each state to develop and implement a comprehensive, integrated health plan for beneficiaries dually eligible for Medicaid and Medicare. Would also expand PACE coverage nationwide to individuals under the age of 55 as well as allow PACE enrollment at any time of the month. ***Potential CalOptima Health Impact:*** Increased coordination and benefits for dually eligible CalOptima Health members; increased enrollment into CalOptima Health PACE.	**03/14/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
	Providers		
S. 3059 Bennet (CO)	**Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act:** Effective plan year 2026, would require MA plans to update and ensure accurate provider directory information at least once every 90 days. If a plan is unable to verify such information for a specific provider, a disclaimer indicating that the information may not be up to date is required. Would also require the removal of a provider from a directory within five business days if the plan determines they are no longer participating in the network. ***Potential CalOptima Health Impact**:* Increased staff oversight of CalOptima Health's OneCare provider directory.	**10/17/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 7149 Steel (CA)	**Equal Access to Specialty Care Everywhere (EASE) Act of 2024:** Would use existing Center for Medicare and Medicaid Innovation funds to test a virtual specialty network dedicated to providing a range of virtual modalities in partnership with primary care providers in underserved and rural communities, including Federally Qualified Health Centers (FQHCs). ***Potential CalOptima Health Impact:*** Expanded telehealth access for CalOptima Health members.	**01/30/2024** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
SB 516 **(SB 598)** Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2026, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. Would also broadly prohibit prior authorization requirements for any services approved by a health plan at least 95% of the time. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider approval rates; decreased number of prior authorizations.	**09/14/2023** SB 516 gutted and amended as new vehicle for SB 598; re-referred to Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	**08/30/2023** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by the California Department of Public Health (CDPH). ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**08/16/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **07/11/2023** Passed Assembly Health Committee **05/04/2023** Passed Senate floor	CalOptima Health: Watch
SB 1268 Nguyen, J.	**Medi-Cal Safety Net Provider Contracts:** Would require a Medi-Cal MCP to offer and maintain a network provider contract with each safety net provider operating within the MCP's geographic service areas unless the safety net provider cannot provide necessary scope of services due to specified, covered reasons. Would prohibit a Medi-Cal MCP from initiating a contract termination for any reason. ***Potential CalOptima Health Impact*:** Revision of current provider contract language; decreased oversight and accountability of contracted providers.	**04/26/2024** Died in Senate Health Committee	**04/15/2024** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually verify and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by July 1, 2025, with increasing percentage accuracy each year until the directories are 95% accurate by July 1, 2028. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Further, beginning July 1, 2025, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. Would also require a plan to arrange care for all covered health services provided to a beneficiary who reasonably relied on inaccurate, incomplete or misleading information contained in a plan's provider directory as well as require the plan reimburse the provider the contracted amount for those services. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**06/26/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **01/30/2024** Passed Assembly floor	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1842 **(AB 1288)** Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of an SUD, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**06/10/2024** Passed Senate Appropriations Committee; referred to Senate floor **05/29/2024** Passed Senate Health Committee **04/29/2024** Passed Assembly floor **01/16/2024** Re-introduced as AB 1842 **10/08/2023** Vetoed as AB 1288 *(see* ***veto message****)*	CalOptima Health: Watch CAHP: Oppose
AB 2110 Arambula	**Adverse Childhood Experiences (ACEs) Trauma Screenings:** Would include Medi-Cal enrolled community-based organizations and local health jurisdictions that provide health services through community health workers and doulas as providers qualified to provide and eligible to receive payments for ACEs trauma screenings. **Potential CalOptima Health Impact:** Increased access to care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing.	**05/17/2024** Died in Assembly Appropriations Committee **04/09/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support
AB 2129 Petrie-Norris	**Immediate Postpartum Contraception:** No later than January 1, 2025, would authorize a provider to separately bill for devices, implants or professional services, or a combination of both, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or accredited birthing center. ***Potential CalOptima Health Impact:*** Modified Claims procedures for a covered Medi-Cal benefit.	**07/03/2024** Senate passage rescinded; re-referred to Senate floor **06/20/2024** Passed Senate floor **05/02/2024** Passed Assembly floor	CalOptima Health: Watch
AB 2339 Aguiar-Curry	**Medi-Cal Asynchronous Telehealth:** Would expand telehealth capabilities to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. Would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when requested by the patient. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities for CalOptima Health Medi-Cal members.	**07/01/2024** Re-referred to Senate floor **06/19/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2726 Flora	**Telehealth and Specialty Care Networks:** Would require CalHHS to establish a demonstration project for a grant program aimed at facilitating telehealth and other virtual services specialty care network for patients of certain safety-net providers, including community health centers and critical access hospitals. The project would focus on increasing access to behavioral and maternal health services as well as other specialties prioritized by CalHHS. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities and virtual specialty networks.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with PBMs under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 3578 Cassidy (LA)	**Protect Medicaid Act:** Would prohibit federal funding for the administrative costs of providing Medicaid benefits to individuals with unsatisfactory immigration status. If states choose to self-fund such costs, this bill would require states to submit a report describing its funding methods as well as the process utilized to bifurcate its expenditures on administrative costs. ***Potential CalOptima Health Impact:*** New financial reporting requirements.	**01/11/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**02/07/2024** Passed House; referred to Senate Finance Committee **03/24/2023** Passed House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**FQHCs and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**07/03/2024** Died in Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 828 Durazo	**Health Care Workers Minimum Wage Delay:** Would delay the minimum wage adjustments enacted pursuant to SB 525 (2023) by one month from June 1, 2024, to July 1, 2024, effective immediately as an urgency statute. ***Potential CalOptima Health Impact:*** No expected impact since CalOptima Health previously increased its minimum wage.	**5/31/2024** Signed into law	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**01/19/2024** Died in Senate Appropriations Committee **04/26/2023** Passed Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1423 Dahle	**Rural Hospital Technical Advisory Group:** Would require DHCS to convene a Rural Hospital Technical Advisory Group to analyze the ability of small, rural and critical access hospitals to remain financially viable under existing Medi-Cal reimbursement methodologies and to provide related recommendations by March 31, 2026. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted critical access hospitals.	**06/25/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/22/2024** Passed Senate floor	CalOptima Health: Watch
SB 1492 Menjivar	**Private Duty Nursing Rate Increases:** Would add private duty services, which are provided to a child under 21 years of age by a home health agency, as an eligible category for the purpose of Medi-Cal rate increases from MCO tax revenue. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted home health agencies.	**05/17/2024** Died in Senate Appropriations Committee **04/24/2024** Passed Senate Health Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, including staffing, the intensity of activities taking place in an average visit, the length or duration of a visit, and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted FQHCs.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2043 **(AB 719)** Boerner	**Public Transit Contracts**: Would require Medi-Cal MCPs to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the Medi-Cal FFS rates for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services that are not on fixed routes. Would also direct DHCS to issue updated guidance by June 1, 2026, to ensure that the financial burden of these services is not unfairly placed on such operators. ***Potential CalOptima Health Impact:*** Increased payments to public paratransit operations for NMT and NEMT services.	**06/12/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor **02/01/2024** Re-introduced as AB 2043 **10/07/2023** Vetoed as AB 719 *(see **veto message**)*	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 2303 Carrillo	**Minimum Wage Add-On Payment:** Would require DHCS to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment to community health centers, in order to accommodate increased labor costs resulting from recently enacted minimum wage increases pursuant to SB 525 (2023). ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health contracted community health centers.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2342 Lowenthal	**Island-Based Critical Access Hospitals:** Would require DHCS to provide an annual supplemental payment for covered Medi-Cal services to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coasts of the state but is still within the jurisdiction of the state. ***Potential CalOptima Health Impact:*** Increased payments to certain critical access facilities for Medi-Cal services.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2428 Calderon	**Community-Based Adult Services (CBAS) Rates:** Would require Medi-Cal MCPs to reimburse contracted CBAS provider at an amount equal to or greater than the Medi-Cal FFS rate. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted CBAS providers.	**06/19/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 3275 Soria	**Claim Reimbursement:** Would require health plans to reimburse a claim, with interest accrued, within 15 working days after receipt of the claim, unless contested by the plan within 15 working days. **Potential CalOptima Health Impact:** Decreased claim review time for CalOptima Health staff; increased interested payments to CalOptima Health contracted providers.	**06/26/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**01/19/2024** Died in Assembly Public Safety Committee **03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 2250 **(AB 85)** Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. In addition, would require FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/05/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2024** Passed Assembly floor **02/08/2024** Re-introduced as AB 2250 **10/07/2023** Vetoed as AB 85 *(see **veto message**)*	CalOptima Health: Watch LHPC: Support

2023 Signed Bills

- H.R. 3746 (McHenry [NC])
- H.R. 5860 (Granger [TX])
- H.R. 6363 (Granger [TX])
- SB 43 (Eggman)
- SB 101 (Skinner)
- SB 311 (Eggman)
- SB 326 (Eggman)
- SB 525 (Durazo)
- SB 496 (Limón)
- SB 770 (Wiener)
- AB 102 (Ting)
- AB 271 (Quirk-Silva)
- AB 557 (Hart)
- AB 118 (Committee on Budget)
- AB 119 (Committee on Budget)
- AB 531 (Irwin)
- AB 425 (Alvarez)
- AB 847 (Rivas, L.)
- AB 904 (Calderon)
- AB 1481 (Boerner)
- AB 1241 (Weber)

2023 Vetoed Bills

- SB 257 (Portantino)
- SB 694 (Eggman)
- AB 608 (Schiavo)
- AB 1060 (Ortega)
- AB 1202 (Lackey)
- AB 931 (Irwin)
- AB 576 (Weber)
- AB 1085 (Maienschein)
- AB 1451 (Jackson)

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

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association
SNP Alliance: Special Needs Plan Alliance

Last Updated: July 19, 2024

2024 Federal Legislative Dates

January 8	118th Congress, 2nd Session convenes
August 5–September 6	Summer recess
September 30–November 11	Fall recess
December 20	118th Congress adjourns

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

2024 State Legislative Dates

January 3	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 12	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2023
January 19	Last day for any committee to hear and report to the floor any bill introduced in that house in 2023
January 31	Last day for each house to pass bills introduced in that house in 2023
February 16	Last day for legislation to be introduced in 2024
March 21–March 30	Spring recess
April 26	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2024
May 3	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2024
May 17	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2024
May 20–24	Floor session only
May 24	Last day for each house to pass bills introduced in that house in 2024
June 15	Budget bill must be passed by midnight
July 3	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 4	Summer recess
August 16	Last day for fiscal committees to report bills in their second house to the Floor
August 19–31	Floor session only
August 23	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2024 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

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

Fiscal Year 2024–25 Enacted State Budget

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Background

On January 10, Gov. Gavin Newsom unveiled his Fiscal Year (FY) 2024–25 Proposed State Budget. With a spending plan of $291.5 billion ($223.6 billion General Fund [GF]), the governor predicted a budget deficit of $37.9 billion – about half the $68 billion initially projected by the Legislative Analyst's Office last year. Gov. Newsom attributed the past two years' shortfall to stock market declines in 2022, driving down revenue and delays in income tax collection. Most proposed budget solutions included reserve withdrawals, loans, fund shifts, and spending delays and deferrals.

To immediately address some of the budget deficit, the administration and California State Legislature attempted to minimize $17.3 billion of the overall shortfall by taking "early action" in April via a limited budget agreement that included some spending cuts that largely avoided health care programs.

Despite efforts in the early budget deal, revenues continued to come in below projections and further increase the deficit by an estimated $7 billion for a new remaining total of $27.6 billion. On May 10, Gov. Newsom released his May Revision to the Proposed State Budget, which largely reversed an agreement to fund Medi-Cal provider rate increases using Managed Care Organization (MCO) tax dollars. The May Revision also proposed several additional spending reductions to health care programs to address both the near-term budget deficit and look beyond FY 2024-25 in hopes of achieving positive operating reserves in the future. On May 29, leaders from both houses of the Legislature released a joint counterproposal to the May Revision, which would have instead delayed future rate increases funded by MCO tax revenues by one-year year from January 1, 2025, to January 1, 2026, rather than eliminate them. On June 13, the State Senate and State Assembly both passed its counterproposal (Assembly Bill [AB] 107) as a placeholder budget to meet the constitutional deadline while negotiations with the governor remained ongoing.

On June 22, Gov. Newsom and legislative leaders announced that a final budget agreement had been reached. After both houses of the Legislatures passed the agreed-upon budget revisions as Senate Bill (SB) 108 on June 26, Gov. Newsom signed both AB 107 and SB 108 into law. Additionally, the governor signed the MCO Tax Trailer Bill (AB 160) and consolidated Health Trailer Bill (SB 159) on June 29, containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2024-25 Enacted State Budget.

Back to Agenda

Overview

The final budget agreement includes obligations to support further resilience by adding financial protection so that the state doesn't overcommit anticipated revenues until it has been completely realized. The enacted budget eliminates the projected FY 2024-25 shortfall of approximately $45 billion and the FY 2025-26 shortfall of over $30 billion through a combination of spending cuts, fund shifts, delays, deferrals and reserves, including utilizing approximately half of the Rainy Day Fund over the next two budget years. Another goal of the final budget agreement is to strengthen the Rainy Day Fund by increasing the maximum limit from 10% to 20% of GF tax revenue, subject to future voter approval, and creating a new "Projected Surplus Temporary Holding Account."

The final Medi-Cal budget includes $161 billion ($35 billion GF) to cover a projected 14.5 million beneficiaries in FY 2024-25 – more than one-third of the state's population.

MCO Provider Tax

The FY 2024-25 Enacted Budget restores several MCO tax investments for future Medi-Cal provider rate increases that were proposed to be eliminated in the governor's May Revision. The final agreement includes $133 million in FY 2024-25, $728 million in FY 2025-26 and $1.2 billion in FY 2026-27 in addition to the approximately $300 million in provider rate increases that already became effective January 1, 2024, and will be maintained. However, total investments are less and partially redistributed compared with the original agreement reached with the MCO tax coalition last year. Some increases will still be effective on January 1, 2025, some will be delayed until January 1, 2026, and others have been eliminated. Additional provider types not included in the MCO tax coalition will now also receive a portion of the investments, further reducing total funding for the originally included provider types.

Effective **January 1, 2025**, Medi-Cal rate increases apply to:

- Emergency Department Physician Services ($100 million)
- Abortion Care and Family Planning ($90 million)
- Ground Emergency Medical Transportation ($50 million)
- Air Emergency Medical Transportation ($8 million)
- Community-Based Adult Services ($8 million)
- Congregate Living Health Facilities ($8 million)
- Pediatric Day Health Centers ($3 million)
- Community Health Workers to achieve 100 percent of Medicare rate

Effective **January 1, 2026**, Medi-Cal rate increases apply to:

- Physician/Non-Physician Professional Health Services ($753 million)
  - Evaluation & Management Codes for Primary Care and Specialist Office Visits, Preventative Services and Care Management (95% of Medicare rate)
  - Obstetric Services (95% of Medicare rate)
  - Non-Specialty Mental Health Services (87.5% of Medicare rate)
  - Vaccine Administration (87.5% of Medicare rate)
  - Vision (Optometric Services (87.5% of Medicare rate)
  - Other Evaluation & Management Codes (80% of Medicare rate)
  - Other Procedure Codes commonly utilized by Primary Care, Specialist and Emergency Department Providers (80% of Medicare rate)
- Private Duty Nursing ($62 million)
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) ($50 million)
- Non-Emergency Medical Transportation ($25 million)

The final agreement allows the California Department of Health Care Services (DHCS) to develop specific rate increase methodologies and supplemental payment amounts, particularly for 2025 investments.

Additional MCO tax investments include $145.4 million in FY 2024-25 to sustain Proposition 56-funded payments to address revenue decline and $40 million in FY 2026-27 for Medi-Cal workforce development through the California Department of Health Care Access and Information (HCAI). The final agreement also includes funding to enact continuous Medi-Cal eligibility for children 0-5, effective January 1, 2026. Notably, if Proposition 35 ("Protect Access to Care" MCO Tax Initiative) is approved by voters in the November 5, 2024, general election, the aforementioned provisions relating to the MCO provider tax will be inoperable since both are not financially sustainable.

CalOptima Health Budget and Provider Rate Increase

CalOptima Health developed our proposed FY 2024-25 operating budget factoring in assumptions related to Medi-Cal program and policy changes, including the state budget. On May 2, the CalOptima Health Board of Directors approved an investment of **$526 million** to increase rates paid to delegated networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers. It is the largest provider rate increase of its kind in our nearly 30-year history. This unprecedented investment is intended to support timely access to critical health care services for members and promote longer-term financial stability of the managed care network over a 30-month period from July 2024 to December 2026. The uncertain nature of the state budget negotiations underscores why CalOptima Health's action to deliver our own separate provider rate increase is so significant.

Continuing Priorities in Medi-Cal

The enacted state budget continues to reflect funding for Medi-Cal benefits that were initially proposed to be eliminated in the May Revision. Key investments that have been protected include but are not limited to:

- Full-scope Medi-Cal coverage and In-Home Supportive Services (IHSS) for all ages, regardless of immigration status.
- **Adult Acupuncture** as a Medi-Cal covered benefit.
- Continued funding for **Health Enrollment Navigators** at clinics, but not at other entities. This does not impact CalOptima Health's own reserve-funded grants for community enrollers.
- **Free Clinics Augmentation** funding.
- Nearly all funding for the **Multifamily Housing Program**.

In addition, the final budget includes $230 million ($115 million GF) for a new directed payment program for children's hospitals to support critically ill children.

Significant Adjustments to Programs

To address the projected budget shortfall, the final budget includes several adjustments in the form of delays, triggers and reductions to certain programs and legislation that has not been implemented. Key program adjustments include but are not limited to:

- $39 million savings in the **Naloxone Distribution Project** from lower naloxone drug costs due to Medi-Cal Rx, while adding $8.3 million in special funds to expand the distribution of naloxone. This does not impact CalOptima Health's own reserve-funded naloxone distribution initiative.
- Reduced funding for **Equity and Practice Transformation (EPT) Program** payments by $111.3 million, which will eliminate the remaining funding for the program but preserve funding previously included in the 2022 Budget Act.
- Reverts all unexpended funds for the **Clinic Workforce Stabilization & Retention Payment Program**.
- Reduces or eliminates funding for several elements of the **Children and Youth Behavioral Health Initiative** (CYBHI), as follows:
  - Eliminates funding for school-linked partnership and capacity grants for community colleges, University of California and California State University systems.
  - Eliminates funding for the services and supports platform.
  - Reduces funding for the public education and change campaign.
  - Allows school districts to use a third-party administrator and/or managed care plans directly for billing related to the school-linked fee schedule.
  - Despite overall reductions, allocates new funding to establish the **wellness coach** benefit, effective January 1, 2025, to provide wellness promotion, education, screening, care coordination, individual and group support, and crisis referral in school-linked settings and across the Medi-Cal behavioral health delivery system.
- Reduces some funding for state and local public health.
- Reverts $450.7 million from the last round of the **Behavioral Health Continuum Infrastructure Program**, which leaves $1.75 billion to support existing projects.
- Reduces and delays funding for **Behavioral Health Bridge Housing** by one year from FY 2024-25 until FY 2025-26.
- Ends continued funding for the **Medication Assisted Treatment** program, which funds startup grants for new treatment facilities.

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that passed legislation.

About CalOptima Health

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

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

CalOptima Health Community Outreach Summary — July and August 2024

Background

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

CalOptima Health's participation in public activities promotes:

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

Community Outreach Highlight

CalOptima Health will host its 2nd Annual Back-to-School Event in collaboration with the Orange County Department of Education on Saturday, August 3 from 9 a.m.–1 p.m. at Columbus Park in Tustin. The event aims to support children and families as they prepare for the new school year by providing health services, community resources and activities. Families will have an opportunity to enroll in Medi-Cal and CalFresh, access health screenings, learn about community resources, and enjoy cultural performances and family activities.

Items featured at the event include full-size hygiene kits, pairs of shoes and socks, backpacks with school supplies, bike helmets, and food and diaper distribution (while supplies last). Vision screenings, eyeglasses, haircuts, dental screenings and sports physicals will also be offered at the event. Additionally, we will provide taco meals, cool refreshments and entertainment to celebrate health and wellness as children and families prepare for the upcoming school year.

Summary of Public Activities

As of July 12, CalOptima Health plans to participate in, organize or convene 52 public activities in July and August. In July, there were 25 public activities, including 10 virtual community/collaborative meetings, five community-based presentations, nine community events and one Health Network Forum. In August, there will be 27 public activities, including 10 virtual community/collaborative meetings, one community-based presentation, 14 community events, one Cafecito and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided four endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for Latino Health's Access submission to U.S. Department of Health and Human Services' Office of Minority Health: Community Level Innovations for Improving Health Outcomes.

2. Letter of support for Jamboree Housing's application to the U.S. Department of Health and Human Services, Administration for Children and Families, Family and Youth Services Bureau, Runaway and Homeless Youth Program for funding through the Transitional Living Program.

3. Letter of support for Hurtt Family Health Clinic's application for the Health Resources and Services Administration Behavioral Health Service Expansion.

4. Letter of support for Serve the People Community Health Center's (Serve the People) Change in Scope application to add a new health center service delivery site at 293 South Main Street, Orange, CA 92868.

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

Attachment to the
August 1, 2024
CalOptima Health
Outreach Summary

Community events hosted by CalOptima Health and community partners in July and August 2024:

July 2024

July 11, 11 a.m.–12 p.m., CalOptima Health Medi-Cal Overview in English

Jewish Family and Children's Services, 1450 N. Tustin Ave., Santa Ana

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

July 12, 10–11 a.m., Thriving and Vibing Community Block Party, hosted by Orange County Department of Education Alternative, Community

OCDE Access, 601 S. Lewis St., Orange

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

July 13, 9:30 a.m.–1 p.m., Summer Family Festival and Resource Fair, hosted by the City of Fullerton and Office of Assemblymember Sharon Quirk-Silva

Hunt Branch Library, 201 S. Basque Ave., Fullerton

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

July 16–18, 7 Annual California Multi-Tiered System of Support Professional Learning Institute, hosted by the Orange County Department of Education

Anaheim Convention Center, 800 W. Katella, Anaheim

- Sponsorship fee: $1,750; included a resource table at event, two complimentary registrations, tiered event recognition and a virtual profile on the event application.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

July 19, 3–6 p.m., Back to School, hosted by Northgate Market

Northgate Market, 720 W. La Palma Ave., Anaheim

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

July 21, 10 a.m.–4 p.m., Community Wellness Fair, hosted by Vital Access Care Foundation (VACF)

St. Norbert Catholic Church, 300 E. Taft Ave., Orange

- Sponsorship fee: $5,000; included a resource booth and logo on event flyer.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted

CalFresh Outreach (e.g., colleges, food banks)

Community Presentation
Exhibitor/Attendee

July 24, 11 a.m.–12 p.m., CalOptima Health Medi-Cal Overview in English
College Community Services Wellness Center, 401 S. Tustin St., Orange
- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

July 24, 3–4 p.m., CalOptima Health Medi-Cal Overview in Spanish
Family Resource Center at Warwick Square Apartments, 780 S. Lyon St., Santa Ana
- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

July 25, 2–3 p.m., CalOptima Health Medi-Cal Overview in English
Santa Ana Family Justice Center, virtual
- At least one staff member presented.
- Community-based organization presentation, open to members/community.

July 25, 4:30–6 p.m., Anaheim Mobile FRC, hosted by the Anaheim Neighborhood and Human Services
Almont/Bellhaven, Anaheim
- Sponsorship fee: $1,000; included a resource booth, recognition on all social media platforms, and featured in a pre-event e-blast.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

July 26, 3–6 p.m., Back to School, hosted by Northgate Market
Northgate Market, 1305 W. Whittier Blvd., La Habra
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

July 27, Noon–4 p.m., Carnival for Kids, hosted by Illumination Foundation
St. Anthony Mary Claret Church, 1450 La Palma Ave., Anaheim
- Sponsorship fee: $1,000; included a resource booth, recognition on social media, and featured in a pre-event e-blast.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

July 28, 9 a.m.–3 p.m., Back to School Community Resource Fair, hosted by the City of Santa Ana Mayor Valerie Amezcua in collaboration with the Asian American Senior Citizens Service Center
Santa Ana Elks Lodge, 1751 Elks Ln., Santa Ana
- Sponsorship fee: $5,125; included a resource booth, three tickets for a VIP meet-and-greet with Mayor Amezcua, sponsor recognitions/signage at the event, logo on event flyer, and recognition on all conference emails, and marketing materials.
- At least 5 staff members attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted

CalFresh Outreach (e.g., colleges, food banks)

Community Presentation

Exhibitor/Attendee

Back to Agenda

July 31, 3–4 p.m., CalOptima Health Medi-Cal Overview in Spanish
Family Resource Center at Warwick Square Apartments, 780 S. Lyon St., Santa Ana
- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

August 2024

August 3, 9 a.m.–1 p.m., Back-to-School Health and Wellness Fair, hosted by CalOptima Health in collaboration with the Orange County Department of Education
Columbus Tustin Park, 14712 Prospect Ave., Tustin
- At least twenty staff members to attend (in person).
- Health/resource fair, open to the public.

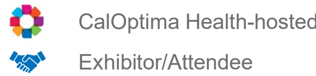
August 3, 9 a.m.–1 p.m., OC Health Fair, hosted by the Korean American Medical Association of Southern CA
Location to be finalized
- Sponsorship fee: $3,000; includes a resource fair booth.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

August 7, 10 a.m.–2 p.m., Back-to-School Backpack Giveaway, hosted by the Delhi Center
Delhi Center, 505 E. Central Ave., Santa Ana
- Sponsorship fee: $1,000; includes logo on the event flyer, display our partnership at event, and a resource fair booth.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

August 10, 10 a.m.–2 p.m., Caregiver Resource Fair, hosted by the Office of Congressman Lou Correa
Downtown Anaheim Community Center, 250 E. Center St., Anaheim
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

August 10, 10 a.m.–2 p.m., 2 Annual Back 2 School Bash, hosted by the City of Anaheim Councilmember Carlos Leon
James Madison Elementary School, 1510 S. Nutwood St., Anaheim
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

August 10, 11 a.m.–2 p.m., Back to School, hosted by Northgate Market
Northgate Market, 770 S. Harbor Blvd., Santa Ana
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.


CalOptima Health-hosted
Exhibitor/Attendee

CalFresh Outreach (e.g., colleges, food banks)

Community Presentation

August 13, 11 a.m.–1 p.m., CalOptima Health Medi-Cal Overview in English

Trinity Cristo Rey Lutheran Church, 902 S. Broadway, Santa Ana

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

August 14, 10 a.m.–1 p.m., Backpacks for Success, hosted by the City of Placentia

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

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

August 14, 6–8 p.m., Family Night, hosted by Santa Ana College

Santa Ana College, 1530 W. 17th St., Santa Ana

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

August 16, 10 a.m.–2 p.m., Annual Senior Wellness Fair, hosted by Moving Forward Institute, Inc.

Kiwanisland, 9840 Larson Ave., Garden Grove

- Sponsorship fee: $2,500; includes a speaking opportunity during the event, engage as a panel speaker in the event's forum, recognition on social media and website, and a resource fair booth.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

August 17, 9 a.m.–Noon, 30 Annual Super Senior Saturday, hosted by the City of Buena Park

Buena Park Senior Activity Center, 8150 Knott Ave., Buena Park

- Registration fee: $300; includes two exhibitor booths.
- At least two staff members to attend (in person).
- Health/resource fair, open to the public.

August 19, 9 a.m.–1 p.m., Federal Resource Fair, hosted by the Office of Congressmember Young Kim

Laguna Woods Village, 24351 El Toro Rd., Laguna Woods

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

August 22, 4:30–6 p.m., Anaheim Mobile FRC, hosted by the Anaheim Neighborhood and Human Services

Philadelphia/Olive, Anaheim

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

August 22, 4–7 p.m., Back-to-School Night, hosted by Garfield Elementary School

Garfield Elementary School, 850 E. Brown St., Santa Ana

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

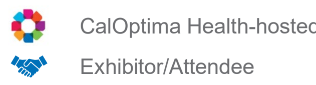
CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation

Exhibitor/Attendee

August 27, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health
Virtual
- At least eight staff members to attend.
- Steering committee meeting, open to collaborative members.

August 27, 11 a.m.–2 p.m., Health Fair, hosted by Irvine Valley College
Irvine Valley College, 5500 Irvine Center Dr., Irvine
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

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



This item is continued to the September 5, 2024 meeting

CalOptima Health Board Action Agenda Referral

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

Report Item

16. Approve Actions Related to a Contract with Advance OC to Conduct the 2024 Member and Population Health Needs Assessment

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

Authorize the Chief Executive Officer to execute a contract with Advance OC for a one-year term effective August 12, 2024, to conduct the 2024 Member and Population Health Needs Assessment for an amount not to exceed $1,000,000.

Background

In April 2024, the Board of Directors (Board) authorized reallocation of $1 million in unspent appropriated funds to conduct a refreshed 2024 Member and Population Health Needs Assessment (MPHNA). The Board also approved the release of a request for proposals (RFP) to procure the services of a research consultant with knowledge of Orange County's diverse populations and opportunities for meaningful outreach and engagement to conduct the 2024 MPHNA. Staff released the RFP on April 24, 2024.

The MPHNA project will:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

Discussion

The RFP sought a consultant to do the following:

1. Design a study to identify, synthesize, and analyze available data to assess member health and population needs.
2. Create a project plan that outlines a timeline with duration of tasks and consultant resources and responsibilities.
3. Provide survey instruments (*e.g.*, member, provider, key informant), focus group facilitation guides, presentations, and other relevant materials.
4. Facilitate member outreach activities in threshold languages as needed to support the approved study design.
5. Develop an MPHNA report and executive summary presentation detailing assessment findings and recommendations.
6. Create a dashboard for member assessment for ongoing reporting.

7. Deliver the data collected and synthesized through the assessment study.

The RFP closed on June 24, 2024, and CalOptima Health received a total of six proposals. All proposals were reviewed by an evaluation committee of CalOptima Health staff and evaluated based on the following criteria:

- Demonstrated understanding and knowledge of the population health needs of Medi-Cal, Medicare, Orange County, and vulnerable populations based on examples of projects of similar size, scope, and complexity;
- Proposed study design and methodology;
- Demonstrated knowledge and experience with data collection and analysis;
- Demonstrated understanding of the importance and role of comprehensive assessment of member needs to inform targeted Medi-Cal managed care plan interventions;
- Demonstrated experience with engaging members and conducting member outreach and/or focus groups;
- Qualifications and experience of the proposer and proposed team;
- Experience with related programs, including NCQA Health Plan Accreditation and Health Equity Accreditation, the Department of Health Care Services Population Needs Assessment and Population Health management Strategy;
- Proposed approach and schedule;
- Differentiators of the project design; and
- Price.

Upon completing the evaluations, the following scores were given to each applicant proposal:

Name	Score	Rank
Advance OC	81.9	1
Health Management Associates (HMA)	78.3	2
Cope Healthcare Consulting, Inc., dba COPE Health Solutions	65.0	3
Accountable Care Transactions Inc. dba Activate Care	61.0	4
RDA Consulting	59.6	5
Syra Health Corp	35.8	6

The evaluation team identified Advance OC as the vendor that best meets CalOptima Health needs. CalOptima Health requested and received a best and final offer from Advance OC on July 22, 2024. The final contract award amount is $1 million.

This item is continued to the September 5, 2024 meeting

The targeted effective date of the new contract with Advance OC is August 12, 2024. The contract will be for a one-year term with one additional one-year extension option, exercisable at CalOptima Health's sole discretion.

Fiscal Impact

The recommended action is funded by a previous Board action on April 4, 2024, that authorized a reallocation of unspent funds of $1 million from CalOptima Health's 2023 Member Health Needs Assessment to support the 2024 MPHNA.

Rationale for Recommendation

Based on the evaluation results of the six proposals received, staff recommends contracting with Advance OC as the vendor that best meets CalOptima Health's objectives for conducting the 2024 MPHNA.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action.
2. Proposed Advance OC Contract No. 25-10109.
3. Previous Board Action April 4, 2024, "Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment."

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

This item is continued to the September 5, 2024 meeting

Attachment to the August 1, 2024 Board of Directors Meeting – Agenda Item 16

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Advance OC	220 Newport Center Drive #11-173	Newport Beach	CA	92660

CONTRACT NO. 25-10109 ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("**CalOptima**")
And
ADVANCE OC
("**Contractor**")

This Contract is made and entered into as of last signed below ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**") and Advance OC, a C Corporation, hereinafter referred to as "**Contractor**." CalOptima and Contractor may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide Health Member and Population Health Needs Assessment, as described in the Scope of Work in Exhibit A;

B. Contractor provides such services;

C. Contractor represents and warrants that it has the requisite personnel and experience and is capable of performing such services;

D. Contractor desires to perform these services for CalOptima; and

E. CalOptima and Contractor desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal 24-064 ("**RFP**"), inclusive of any CalOptima revisions and addenda prior to the Effective Date; (iii) Contractor's best and final offer dated 07/19/2024, and; (iv) Contractor's proposal dated 06/13/2024 ("**Proposal**"). Any new terms and conditions attached to Contractor's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

   2.1 Contractor shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1 At Contractor's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, Contractor shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. Contractor shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, Contractor shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for Contractor. Contractor's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of Contractor, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to Contractor's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the Contractor's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the Contractor's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

3.2.3 Contractor's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the Contractor for CalOptima. This provision applies to the Contractor's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 Contractor shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the Contractor to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the Contractor and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If Contractor maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If Contractor fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to Contractor. Such termination shall not affect Contractor's right to be paid for its time and materials expended prior to notification of termination. Contractor waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 Contractor shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out Contractor's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. Contractor shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. Contractor's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of Contractor, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.2 Contractor's obligation to indemnify hereunder is in addition to any liability Contractor may have to CalOptima for a breach by Contractor of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit Contractor's indemnification and duty to defend obligation or other liability hereunder

4.3 Contractor's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and Contractor agree that Contractor, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the Contractor, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. Contractor's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. Contractor's personnel performing services under this Contract shall be at all times under Contractor's exclusive direction and control and shall be employees of Contractor and not employees of CalOptima. Contractor shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. Contractor shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 Contractor Staffing. Contractor shall ensure that only fully qualified Contractor personnel are assigned to perform the services under the Contract, and such Contractor personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 Contractor Personnel Restrictions. When on CalOptima's premises, Contractor personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by Contractor, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by Contractor at no cost to CalOptima.

7. Compensation.

7.1 CalOptima agrees to pay, and Contractor agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

7.2 CalOptima will not reimburse Contractor any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

7.3 Contractor's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract, including in Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY Contractor IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4 In no event shall the total compensation payable to Contractor for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **Contractor ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

7.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. Contractor is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be

withheld on any amounts otherwise to be paid by CalOptima to Contractor due to Contractor's failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 Contractor shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of Contractor. Those security procedures and other safeguards shall be no less rigorous than those maintained by Contractor for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 For the purposes of Section 8.6 only, Confidential Information does not include protected health information ("**PHI**") or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and other privacy statutes or regulations. The access use and disclosure of PHI shall be governed by a BAA, which is Exhibit H to this Contract.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). Contractor hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by Contractor. If Contractor discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless Contractor marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that Contractor has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any Contractor's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses Contractor materials that have been properly marked, CalOptima will provide Contractor with notice thereof to allow Contractor to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, Contractor shall notify CalOptima if it intends to object to production of Contractor's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. Contractor agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought Contractor's marked material, arising out of or related to CalOptima's failure to produce or provide the Contractor-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). Contractor shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to Contractor at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and Contractor. Execution of amendments shall be contingent upon Contractor's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for Contractor's performance.

11. Assignments.

11.1 Contractor may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, Contractor acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in Contractor (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of Contractor (whether in a single transaction or in a series of transactions); (3) the merger,

reorganization, or consolidation of Contractor with another entity with respect to which Contractor is not the surviving entity; and/or (4) a change in the management of Contractor from management by persons appointed, elected or otherwise selected by the governing body of Contractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. Contractor may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through 07/30/2025 ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to One (1) additional consecutive one (1)-year terms ("**Extended Terms**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving Contractor thirty (30) days' prior written notice. Upon termination, CalOptima shall pay Contractor all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, Contractor shall have no further claims against CalOptima under this Contract.

14.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

14.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay Contractor all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Contractor shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to Contractor for (i) Contractor's bankruptcy, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against Contractor; or (iii) if Contractor makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach, provided that the non-breaching party may terminate the Contract immediately upon written notice if the non-breaching Party reasonably determines that cure of the default within thirty (30) days is impossible. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon Contractor's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 Contractor shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by Contractor in performing this Contract, whether completed or in process. If Contractor personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

14.6.3 In the event of termination under Sections 14..3, 14.4, or 14.5, either Party shall be liable for any and all reasonable costs incurred by the non-breaching Party as a result of such a termination.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and Contractor. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. Contractor warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to Contractor on CalOptima's website.

16.3 Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other Party in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining the other Party's express written approval of the material and consent to such use.

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To Contractor:	**To CalOptima Health:**
Advance OC	CalOptima Health
	505 City Parkway West
	Orange, CA 92868
Attention: Katie Kalvoda	Attention: Maria Medina
Email: katie@advanceoc.com	Email: mmedina@caloptima.org

16.8 Notice of Labor Disputes. Whenever Contractor has knowledge that any actual or potential labor dispute may delay this Contract, Contractor shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between Contractor and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between Contractor and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 25-10109 on the day and year last shown below.

Advance OC	CalOptima Health
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

1. **Description of Work**

1.1. OBJECTIIVE

Contractor should conduct a comprehensive Member and Population Health Needs Assessment (MPHNA). The purpose of the MPHNA is to:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

1.2. SCOPE OF WORK

The Contractor should provide professional research and analytical services that has detailed knowledge of Medi-Cal, Medicare, and Orange County populations. The Contractor shall have demonstrated expertise and knowledge in analyzing population and member level data and producing detailed analyses and dashboards to present study findings. The Contractor shall be able to analyze existing CalOptima Health and community data sources and also propose approaches to obtaining member, provider, and community input through interviews, surveys and/or focus groups.

Consulting services will be for the purpose of taking a strategic approach to consolidating related CalOptima Health efforts to assess population health data (including members and potential members) that meets deliverable requirements as outlined by the Department of Health Care Services (DHCS), NCQA, and other related requirements. These contracted services will inform and support CalOptima Health in achieving the following objectives:

- Meet the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, Population Needs Assessment (PNA), and Medi-Cal Transformation initiatives.
- Meet the requirements of NCQA Health Plan Accreditation PHM Standards, PHM 2, including Elements A (Data Integration), B (Population Assessment), and D (Segmentation).
- Meet the requirements of NCQA Health Equity Accreditation as applicable.
- Understand the detailed member and population needs of our member population and community, including in the domains outlined in this scope of work.
- Understand member experience with CalOptima Health services and recommendations for future service offerings.
- Identify opportunities to advance health equity with our member population.

The MPHNA areas of assessment will include *but not be limited to* the attributes/domains of the CalOptima Health member population as outlined in the table below. CalOptima Health aims to assess these areas for our entire member population as well as for subsets of the member population, including child and adolescent members, members with disabilities, members with serious mental illness or serious emotional disturbance, members of racial or ethnic groups, members with limited English proficiency, and other relevant subpopulations.

Assessment Domain	Areas for Analysis
Demographics of Member Population	• Age • Race • Ethnicity • Language

Assessment Domain	Areas for Analysis
	• Sexual Orientation • Gender Identity • Etc.
Health Status and Health Conditions	• Chronic conditions/disease prevalence (e.g., asthma, diabetes, chronic obstructive pulmonary disease, etc.) • Member risk profile • Births • High-risk pregnancy • Behavioral health conditions • Smoking • Substance use disorder • Disparities • Vaccination rates • Select Healthcare Effectiveness Data and Information Set (HEDIS) measures
Social Conditions	• Social determinants of health needs • Barriers to getting needed help • Barriers to economic mobility • Transportation challenges • Etc.
Health Equity	• Challenges with accessing care (e.g., language, health literacy, affinity with providers, etc.) • Challenges with accessing social supports • Member experience • Cultural preferences
Access to Care and Supports	• Barriers to accessing care and support (e.g., childcare, hours of operation, not enough information, unable to find a provider, no appointments available/delays in timely access, etc.) • Access to behavioral health services and barriers • Services most and least utilized • Unmet care needs • Eligibility loss/churn/income changes
CalOptima Health Services & Supports	• Experience with CalAIM services • Medicare supplemental benefits • Participation in other coverage programs • How CalOptima Health partners in their communities

The project shall incorporate coordination and collaboration with CalOptima Health and external partners (e.g., Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

1.3. **CONTRACTOR'S RESPONSIBILITIES**

Contractor shall:

1. Develop a study design to identify, synthesize, and analyze all available data to assess member health and population needs, including but not limited to:
   a. CalOptima Health internal data
   b. Additional data sources, i.e., the county Community Health Needs Assessment, etc.

   c. Member input through a small-scale member survey to fill gaps in existing data, focus groups, etc.
   d. Community input
   e. Provider input

The Study design must outline study methodologies, data sources, and data collection methods. The study design must be presented to CalOptima Health for review and input prior to finalization. It will also be presented to the CalOptima Health Member and Provider Advisory Committee and potentially other community forums for comment.

2. Develop a detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities. The timeline should be developed in partnership with CalOptima Health staff to account for regulatory approval timelines where necessary. The project plan must be updated throughout the project if timelines change.

3. Develop MPHNA deliverables that will be presented to CalOptima Health for review and approval, including if applicable:
   a. Final survey instruments (e.g., member, provider, key informant)
   b. Focus group facilitation guides, presentations, and other relevant materials
   c. Outreach and engagement materials for member communication and community organization communication

   All member facing materials must be translated in all threshold languages. All member facing materials must also be submitted for review to CalOptima Health. CalOptima Health may be required to submit certain materials to the Department of Health Care Services for review and approval, and timelines should be constructed to allow such approval time.

4. Facilitate member outreach and engagement activities in threshold languages in partnership with CalOptima Health and community organizations (e.g. member incentives, focus groups, community, or member forums, etc.) as needed to support the approved study design.

5. Provide interim assessment deliverables for NCQA filings if needed. These interim deliverables may include a preliminary assessment of internal and secondary data sources and obtaining member input from existing member committees and forums.

6. Develop final MPHNA report and executive summary presentation to CalOptima Health and its leadership detailing assessment findings and recommendations.

7. Produce dashboard for member assessment that can be utilized by CalOptima Health staff and stakeholders for ongoing population needs assessment reporting.

8. Deliver data set collected and synthesized through the conduct of the assessment study.

9. Schedule and conduct regular meetings with CalOptima Health staff to present relevant findings and project status.

10. Present MPHNA findings to the CalOptima Health Board of Directors.

The Contractor must perform all work according to industry and professional standards and in a manner satisfactory to CalOptima Health and, if applicable, regulatory and accreditation requirements.

The Contractor may propose to utilize subcontracted services for survey administration and/or focus group facilitation to ensure alignment of skills with services. The Contractor is responsible for ensuring that performance and completion of project deliverables by any and all subcontractors align with the responsibilities outlined in this scope of work.

1.4. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health staff shall:

1. Provide a point of contact and meet regularly with the Consultant/Contractor to discuss project status, open questions, and deliverable development.
2. Provide documentation on requirements for Consultant/Contractor to review and key resources and department point of contacts.
3. Provide guidance on regulatory and CalOptima Health's requirements.
4. Work collaboratively with Consultant/Contractor to promote member and provider surveys, if included in the study design.
5. Provide and distribute Member Incentives (if applicable).
6. Utilize existing community relationships to make introductions for the Consultant/Contractor to connect with these organizations.
7. Facilitate CalOptima Health internal approvals and DHCS regulatory approvals as needed.
8. Provide Consultant/Contractor with points of contact to administer community leader/key informant and provider interviews (if applicable).

1.5. TIMELINES

This contract will continue through the completion of deliverables outlined in the Scope of Work, with a framework that can be leveraged for annual refreshing on a go-forward basis of the MPHNA to meet NCQA requirements. Consultant/Contractor shall:

1. Begin project planning in September 2024, with implementation through Q1 2025.
2. On an ongoing basis, meet regularly with CalOptima Health to assess progress and opportunities and share findings with CalOptima Health.

2. **Standard of Performance; Warranties**.

2.1 Contractor agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If Contractor may subcontract for services under this Contract, then Contractor represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 Contractor expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. Contractor further warrants that all material covered by this Contract, if any, which is the product of Contractor will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to Contractor. Contractor shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to Contractor of any observed defects. If Contractor fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge Contractor the costs incurred.

2.4 Contractor's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 Contractor's obligations under this Section 2 are in addition to Contractor's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against Contractor for faulty materials, equipment or work. CalOptima rejects any disclaimer by Contractor of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by Contractor, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by Contractor at no cost to CalOptima.

3. **Record Ownership and Retention**.

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for Contractor's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. Contractor shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 Contractor hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter Contractor created in these Works. Contractor agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, Contractor will return or transfer all property and materials, including the Works, in Contractor's possession or control belonging to CalOptima.

4. **Required Insurance**

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

4.2. If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3. Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of Contractor's employees:

4.3.1. The policy must provide statutory coverage for Worker's Compensation.

4.3.2. The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4. Professional Liability insurance covering the Contractor's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate.

4.5. Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

4.6. Cyber Liability insurance with the minimum limits of insurance listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

4.6.1. One Million ($1,000,00.00) each occurrence/claim and One Million ($1,000,00.00) aggregate.

4.7. "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

1. For Contractor's full and complete performance of its obligations under this Contract, CalOptima shall pay Contractor for fees and expenses in accordance with the provisions of this Exhibit B and subject to the maximum cumulative payment obligations specified below.

2. Contractor shall invoice CalOptima on a monthly basis for actual labor hours expended. The hourly rates, as defined below, are acknowledged to include Contractor's base labor rates, overhead and profit. Work completed shall be documented in a monthly progress report prepared by Contractor, which report shall accompany each invoice submitted by Contractor. Contractor shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as Contractor has documented, to CalOptima's satisfaction, that Contractor has fully completed all work required under this Contract and Contractor's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of Contractor's work under this Contract.

3. Contractor shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 25-10109; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and Contractor mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed $1,000,000.00, including all amounts payable to Contractor for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

5. CONTRACTOR's rates for the goods and/or services provided under Exhibit A, Scope of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one (1) year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. If Contractor incurs travel-related expenses under this Contract, CalOptima will only reimburse such expenses if CalOptima provides prior written approval of such expenses and those expenses are incurred and submitted in accordance with CalOptima Travel Policy (G.A.5004), as amended, which is incorporated into this Contract by this reference. CalOptima will make CalOptima Travel Policy (G.A.5004) available to Contractor upon written request.

EXHIBIT B-1
Payment/Rates Schedule

Milestone Payment:

Milestone	Amount	Cumulative Total
Upon Contract Execution	$100,000.00	$100,000.00
Completion of Task 1	$60,000.00	$160,000.00
Completion of Task 2	$60,000.00	$220,000.00
Completion of Task 3	$90,000.00	$310,000.00
Completion of Task 4	$90,000.00	$400,000.00
Completion of Task 5	$140,000.00	$540,000.00
Completion of Task 6	$90,000.00	$630,000.00
Completion of Task 7	$130,000.00	$760,000.00
Completion of Task 8	$140,000.00	$900,000.00
Completion of Task 9	$80,000.00	$980,000.00
Completion of Task 10	$20,000.00	$1,000,000.00

Rates:

Project Milestone (Itemize)	Estimated Timeline	Approx. Number of Hours	Approximate Cost
Task 1: Kickoff Meeting and Landscape Analysis	**September – October 2024**	**500**	**$60,000.00**
Advance OC will review research reports currently in existence, identify any voids or blind spots in data, determine best practices for comprehensive assessment.			
Enumerate goals and objectives, prioritizing them to meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.			
Co-create a Work Plan that can leverage existing pipeline projects or events and building a cadence for regular communication touch points.			
Task 2: Data Discover	**September – October 2024**	**500**	**$60,000.00**
Meet with the team at CalOptima Health and other stakeholders to determine high impact targets for the assessment and take an inventory of data previously collected and measured. Key objectives is to determine KPIs from management and evaluate the data and technology environment for dashboard development and integration. CalOptima Health member data will be prepped, cleaned and structured for analysis.			
Task 3: Key Informant Interviews	**September – December 2024**	**800**	**$96,000.00**
Design the research protocols for stakeholder interviews, identify and cultivate a list of key stakeholders to engage. Coordinate and conduct these interviews, in language if necessary. Assemble, transcribe, analyze, and collate findings for CalOptima Health.			
Task 4: Member Survey	**September – December 2024**	**800**	**$96,000.00**
Advance OC will conduct a well-designed member survey of CalOptima members, which will be stratified into five subgroups: (1) age, (2) race/ethnicity, (3) language, (4) sexual orientation, and (5) gender Identity translated into six languages (Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese). Historically underrepresented segments of the community will be specifically targeted to provide a representative sample and to achieve a margin of error of 5% or less with a confidence interval of 95%.			

Project Milestone (Itemize)	Estimated Timeline	Approx. Number of Hours	Approximate Cost
Task 5: Secondary Data Aggregation	**September 2024– January 2025**	**1200**	**$144,000.00**
Collect and synthesize secondary data from national, state, and local sources to present insights at the census tract level for geolocation data intelligence.			
Task 6: Provider Survey	**November 2024 – February 2025**	**800**	**$96,000.00**
Design the research protocols for a provider survey, identify and cultivate a list of primary providers to engage. Disseminate the provider survey in RFP specified languages. Analyze and collate findings for CalOptima Health.			
Task 7: Focus Groups	**November 2024 – February 2025**	**1200**	**$144,000.00**
Design the research protocols for focus groups, identify and cultivate a list of primary content areas and participants in which to engage. Coordinate and facilitate focus group meetings in language. Assemble, transcribe, analyze, and collate findings for CalOptima Health.			
Task 8: Data analysis, Dashboard Development and Data Validation	**December 2024 – March 2025**	**2000**	**$240,000.00**
Primary and secondary data will be analyzed by a team of social and data scientists. The MPHNA report will be accompanied by public dashboards that will be created to visualize the data collected throughout the assessment. Advance OC envisions an interactive and user-friendly website with embedded tableau workbooks to spotlight top health needs and findings from the assessment. Custom domain, software licenses, website security is included.			
Task 9: Data Discover	**March 2025**	**500**	**$60,000.00**
Prepare and finalize a draft of the final report, designed, and formatted to be ready for print.			
Task 10: Data Delivery to CalOptima Health		**40**	**$4,000.00**
	Total	**8340**	**$1,000,000.00**

<u>EXHIBIT C</u>
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This <u>Exhibit C</u> sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. <u>Compliance with Medi-Cal Standards</u>. Contractor agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract, including 42 C.F.R. § 438.230; Health & Safety Code § 1340 *et seq*. (unless otherwise excluded under the DHCS Contract); 28 C.F.R. § 1300.43 *et seq*.; Welfare & Institutions Code § 14000 *et seq*.; and 22 C.C.R. §§ 53800 *et seq*., 22 C.C.R. §§ 53900 *et seq*. Contractor and Subcontractors shall comply with all applicable requirements of the Medi-Cal program pertaining to its reporting requirements and other obligations under this Contract, including Medicaid and Medi-Cal laws and regulations, sub-regulatory guidance, DHCS all plan letters, and the DHCS Contract and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS. CalOptima or DHCS may revoke any activity under this Contract, including terminating this Contract, if Contractor and/or its Subcontractors do not perform that activity in compliance with the requirements in this <u>Exhibit C</u>. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.7-B.8, B.11, B.28; 42 C.F.R. § 438.230]

1.2. <u>Disclosure of Officers, Owners, Stockholders and Creditors</u>. Pursuant to Exhibit A, Attachment III, § 1.3.5 of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, Contractor shall identify the names of the following persons by listing them on <u>Exhibit D</u> of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the Contractor;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by Contractor; and

1.2.3. All creditors of Contractor's business if such interest is over five percent (5%).

1.3. <u>Compliance with Employment and Labor Laws</u>. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. Contractor acknowledges and agrees that:

1.3.1. Contractor and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Contractor and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Contractor and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices provided by the federal government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Contractor and its subcontractors'

obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(f), Provision 1.a.]

1.3.2. Contractor and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Contractor and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(f), Provision 1.b.]

1.3.3. Contractor and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of Contractor and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(f), Provision 1.c.]

1.3.4. Contractor and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(f), Provision 1.d.]

1.3.5. Contractor and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(f), Provision 1.e.]

1.3.6. If Contractor and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Contractor and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(f), Provision 1.f.]

1.3.7. Contractor and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such

provisions will be binding upon each subcontractor. Contractor and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Contractor and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, Contractor and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(f), Provision 1.g.]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the Contractor agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(f), Provision 20.a.]

1.4.2. By signing this Contract, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(f), Provision 20.b.(1)]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(f), Provision 20.b.(2)]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(f), Provision 20.b.(3)]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(f), Provisions 20.b.(4)(5)]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(f), Provision 20.b.(6)]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(f), Provision 20.b.(7)]

1.4.3. If the Contractor is unable to certify any of the statements in this certification, the Contractor shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(f), Provision 20.c.]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(f), Provision 20.d.]

1.4.5. If the Contractor knowingly violates this certification, in addition to other remedies available to the federal government, Contractor shall promptly notify CalOptima in writing, and CalOptima may terminate this Contract for cause. [DHCS Contract, Exhibit D(f), Provision 20.e.]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, Contractor and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that Contractor and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(f), Provision 37.a.(1); 31 U.S.C. § 1352]

1.5.1.2. Contractor and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if Contractor and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(f), Provision 37.a.(2)]

1.5.1.3. Contractor and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Contractor and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(f), Provision 37.a.(3)]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(a)]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(b)]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(c)]

1.5.1.3.4. As applicable and required by this Section 1.5, Contractor's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(f), Provision 37.a.(4)]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by Contractor. Contractor shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(f), Provision 37.a.(5)]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the

extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(f), Provision 37.b.]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, Contractor will timely gather, preserve, and provide, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of Contractor that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. Contractor and Subcontractors must maintain all books and records in accordance with good business practices and generally accepted accounting principles. This provision shall also apply to any agreement with a Contractor Subcontractor or an organization related to a Contractor Subcontractor by control or common ownership. Contractor further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records and any additional relevant information that regulating entities may require. Contractor further agrees and acknowledges that this provision will be included in any and all agreements with Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.12-B.15]

1.7. Confidentiality of Member Information.

1.7.1. If Contractor and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, Contractor and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Contractor, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and Contractor's obligations under this Contract. Contractor and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by Contractor from unauthorized disclosure. Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by Contractor or its subcontractors, Contractor will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Contractor by CalOptima for this purpose. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.8. Member Hold Harmless. To the extent Contractor provides services or supplies to CalOptima members, Contractor hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. Contractor further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Contractor and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections A.13 and B.18; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Member Grievances. Contractor shall cooperate with CalOptima's member grievances and appeals procedures as necessary for CalOptima to carry out its legal obligations. [DHCS Contract, Exhibit A, Attachment III § 4.6; 28 C.C.R. §§ 1300.68, 1300.68.01; 22 C.C.R. § 53858; 43 C.F.R. § 438.402-424]

1.10. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), Contractor agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(f), Provision 12]

1.11. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5, subsection B.4]

1.12. Prospective Requirements. CalOptima will inform Contractor of prospective requirements added by the State, federal law, or DHCS to the DHCS Contract that would impact Contractor's obligations before the requirement becomes effective. Contractor agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. Contractor will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.22 and B.23]

1.13. DHCS Beneficiary. Contractor expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor agreement with respect to the obligations and functions undertaken under the Contract, and (ii) DHCS may directly enforce any and all provisions of the Contract or Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.29]

1.14. Termination. Contractor shall notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.17; APL 19-001, Attachment A, Requirement 13]

1.15. Cultural Competency. Contractor and Subcontractors must ensure that cultural competency, sensitivity, health equity, and diversity training is provided for Contractor's and Subcontractor's staff at key points of contact with CalOptima members, if applicable. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.24]

1.16. Interpreter Services. Contractor and Subcontractors, to the extent they communicate with CalOptima members, will provide interpreter services for members and comply with language assistance standards developed pursuant to Health and Safety Code § 1367.04 [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.25]

1.17. Fraud Reporting. Contractor and Subcontractors must notify CalOptima within ten (10) business days of any suspected fraud, waste, or abuse, and CalOptima may share such information with DHCS in

accordance with Exhibit A, Attachment III, Section 1.3.2 (D), Fraud and Abuse Reporting, of the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.26]

1.18. Overpayment Reporting. Contractor and all Subcontractors must report directly to CalOptima, or through Contractor or Subcontractor, as applicable, when it has received an overpayment; return the overpayment to CalOptima within sixty (60) calendar days after the date the overpayment was identified; and notify CalOptima in writing of the reason for the overpayment. [42 C.F.R. § 438.608(d)(2); DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.27]

2. **Medicare Requirements**.

2.1. Contractor expressly warrants that Contractor and Contractor's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. Contractor further agrees and acknowledges that this provision will be included in all agreements with Contractor's subcontractors.

2.2. For any medical records or other health and enrollment information Contractor maintains with respect to Medicare enrollees, Contractor shall establish procedures to:

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. Contractor shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within Contractor's organization; and (b) to whom and for what purposes Contractor will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

2.2.3. Maintain the records and information in an accurate and timely manner.

2.3. Contractor shall cooperate with CalOptima as necessary for CalOptima to comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, including Sections 422.516 and 422.310.

2.4. Contractor shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.5. For all contracts in the amount of $100,000 or more, Contractor and Contractor's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.5.1. Contractor and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.5.2. Contractor and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.6. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS, DHCS, or CalOptima determines that Contractor has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay Contractor its allowable costs incurred to the date of termination. Thereafter, Contractor shall have no further claims against CalOptima for matters pertaining to this Contract.

2.7. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, Contractor shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.8. Contractor shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. Contractor shall promptly disclose to CalOptima any exclusion or other event that makes a Contractor employee or subcontractor ineligible to perform work related to federal health care programs. Contractor agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. Contractor shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. Contractor represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. Contractor is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. Contractor shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

4.2. Contractor covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. [22 C.C.R. § 53600(d)]. Contractor further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or contractor position by Contractor within one (1) year after the state office or state employee has terminated state employment.

4.3. Contractor, and any person designated by Contractor to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

4.4. Contractor understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, Contractor will not be entitled to any compensation for services performed pursuant to this Contract, and Contractor will be required to reimburse CalOptima any sums

paid to Contractor. Contractor further understands that Contractor may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.5. If Contractor becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, Contractor shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, Contractor agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of Contractor relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: ____

Business Entity Type: ____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: ______________________________________

City:______________________ State:______________ Zip:__________

Business Phone:______________________ Email: :______________________

President: ______________________ Contact Person:______________

Person(s) Signing Contract & Title: :______________________

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
______________________	______________________________
______________________	______________________________
______________________	______________________________
______________________	______________________________

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

___________________________________ _______________
Authorized Signature Date

____
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

______________________________	______________________________
Name of Contractor	Printed Name of Person Signing for Contractor
______________________________	______________________________
Contract/Grant Number	Signature of Person Signing for Contractor
______________________________	______________________________
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_______ date of last report _____________

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $________________
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(attach Continuation Sheet(s) SF-LLLA, if necessary)

11. Amount of Payment (check all that apply): $_______________ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____________ Value_____________	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: __________

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

EXHIBIT F
Not Applicable

EXHIBIT G

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal
Please check one of the following: ☐ Our Organization does not offshore any protected health information. **Please skip to Part V below** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below**	

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*

*Explanation required for all "no" responses to Part III and Part IV above:

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H

Business Associate Agreement

This Business Associate Agreement by and between CalOptima and Contractor, which for the purposes of this Agreement shall be referred to as "**Business Associate**", is effective as of the Effective Date of the Agreement or Memorandum of Understanding attached hereto.

RECITALS

WHEREAS, the Parties have executed an agreement(s) whereby Business Associate provides services to CalOptima, and Business Associate creates, receives, maintains, uses, transmits protected health information ("**PHI**") in order to provide those services ("**Services Agreement(s)**");

WHEREAS, as a covered entity, CalOptima is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("**HIPAA**") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations ("**C.F.R.**") Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("**Privacy Regulations**") and the Security Standards for Electronic Protected Health Information ("**Security Regulations**") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Business Associate is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

WHEREAS, CalOptima's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators' PHI and have required that CalOptima incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators' PHI;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the Parties agree as follows:

1. **Definitions**. The terms in this section and otherwise defined in this Business Associate Agreement shall have the definitions set forth below for purposes of this Business Associate Agreement. Terms used, but not otherwise defined, in this Business Associate Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, the IPA (as defined below), and/or regulations promulgated thereunder.

    1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

    1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, Use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

    1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential Information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data Aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated Record Set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **Disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic Health Record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic Media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** (“**ePHI**”) means Individually Identifiable Health Information, including PHI, that is transmitted by or maintained in Electronic Media.

1.11. **Health Care Operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually Identifiable Health Information** means health information, including demographic information collected from an Individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, that identifies the Individual or where there is a reasonable basis to believe the information can be used to identify the Individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information System** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** (“**PHI**”), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information (“**PI**”) as defined in the Information Practices Act at California Civil Code § 1798.3(a) (“**IPA**”). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Reproductive Health Care** means health care, as defined at 45 CFR § 160.103, that affects the health of an Individual in all matters relating to the reproductive system and to its functions and processes.

1.17. **Required by Law** means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.18. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.19. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

1.20. **Services** has the same meaning as in the Services Agreement(s).

1.21. **Unsecured Protected Health Information** ("**Unsecured PHI**") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.22. **Use** and **Uses** mean, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute PHI and/or Confidential Information protected by federal and/or state laws.

3. Business Associate is the business associate of CalOptima acting on CalOptima's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of CalOptima, and may create, receive, maintain, transmit, aggregate, Use or Disclose PHI in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may Use or Disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of CalOptima, provided that such Use or Disclosure would not violate HIPAA, including the Privacy Regulations, or other applicable laws if done by CalOptima.

4.1. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may Use and Disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may Disclose PHI for this purpose if the Disclosure is Required by Law, or the Business Associate obtains reasonable assurances, in writing, from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

4.2. **Data Aggregation**. If authorized as part of the Services provided to CalOptima under the Services Agreement, Business Associate may Use PHI to provide Data Aggregation services relating to the Health Care Operations of CalOptima.

5. **Prohibited Uses and Disclosures of PHI**

5.1. **Restrictions on Certain Disclosures to Health Plans**. Business Associate shall not Disclose PHI about an Individual to a health plan for payment or Health Care Operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

5.2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima and CalOptima's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

5.3. **Prohibition of Disclosure of PHI Related to Reproductive Health Care**. Business Associate shall comply with 45 C.F.R. Part 164, Subpart E regarding uses and disclosures of Reproductive Health Care-related information, including the following:

5.3.1. Business Associate shall comply with requirements of 45 § C.F.R. 164.502(a)(5)(iii) and shall not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described (each a "**Prohibited Purpose**").

5.3.2. To the extent applicable, if Business Associate receives a request for Reproductive Health Care-related information for a non-Prohibited Purpose that is otherwise permissible under HIPAA, HITECH, the Privacy Regulations, and the Security Regulations, Business Associate shall obtain a valid attestation under 45 C.F.R. § 164.509 if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under 45 C.F.R. § 164.512(d); (ii) judicial or administrative proceedings under 45 C.F.R. § 164.512(e); (iii) disclosures for law enforcement purposes under 45 C.F.R. § 164.512(f); or (iv) disclosures about decedents to coroners and medical examiners under 45 C.F.R. § 164.512(g)(1).

6. **Compliance with Other Applicable Laws**

6.1. To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, "**more protective**") privacy and/or security protections to PHI or other Confidential Information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

6.1.1. To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the Individuals whose information is concerned; and

6.1.2. To treat any violation of such additional and/or more protective standards as a Breach or Security Incident, as appropriate, pursuant to Section 17 of this Agreement.

6.2. Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or Confidential Information, as defined in Section 1.4 of this Agreement, include, but are not limited to the IPA, California Civil Code §§ 1798-1798.78, California Confidentiality of Medical Information Act ("**CMIA**"), Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5. Business Associate shall ensure that any Medical Information related to Sensitive Services (as those terms are defined under Civil Code § 56.05) received or accessed under the Agreement is kept confidential, segregated, and only disclosed, accessed, transferred, transmitted, or processed in accordance with CMIA requirements, including Civil Code §§ 56.10, 56.11, 56.107, 56.108, and 56.110, as applicable.

6.3. If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

7.1. **Nondisclosure**. Business Associate shall not Use or Disclose PHI or other Confidential Information other than as permitted or required by this Agreement or as Required by Law.

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent Use or Disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

7.2.2. Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls, and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time.

7.2.3. Business Associate shall employ FIPS 140-3 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other Confidential Information, including, but not limited to, encryption of all

workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

7.2.4. Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other Confidential Information may be used.

7.2.5. Business Associate shall ensure that all members of its workforce with access to PHI and/or other Confidential Information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

7.2.6. Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 C.F.R. Part 164, Subpart C.

7.3. **Minimum Necessary**. With respect to any permitted Use, Disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **Business Associate's Agent**. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "**Agents**") that Use or Disclose PHI and/or Confidential Information on behalf of Business Associate agree through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or Confidential Information.

8. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or disclosure of PHI and other Confidential Information in violation of the requirements of this Agreement.

9. **Access to PHI**. Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima. If Business Associate maintains an Electronic Health Record with PHI and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524.

9.1. **Business Associate of CalOptima PACE**. This Section applies when Business Associate is a business associate of CalOptima in CalOptima's capacity as a health care provider through CalOptima Program of All-Inclusive Care for the Elderly ("**CalOptima PACE**"). Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set or patient records (as defined in California Health and Safety Code § 123105), make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. To enable compliance with California Health & Safety Code § 123110 and 45 C.F.R. § 164.524, Business Associate shall provide such access for inspection of that PHI within three (3) working days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima.

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526, as requested by CalOptima in the time and manner designated by CalOptima.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima or (at the direction of CalOptima) to an Individual such disclosures of PHI and information related to such disclosures as necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations, including 45 C.F.R. § 164.528. Unless directed by CalOptima to make available to an Individual, Business Associate shall provide to CalOptima, within thirty (30) calendar days after receipt of request from CalOptima, information collected in accordance with this Section 11 to permit CalOptima to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

    11.1. The date of the disclosure;

    11.2. The name, and address if known, of the entity or person who received the PHI;

    11.3. A brief description of the PHI disclosed; and

    11.4. A brief statement of the purpose of the disclosure.

    For each Disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima or DHCS**. To the extent Business Associate is to carry out an obligation of CalOptima or the California Department of Healthcare Services ("**DHCS**") under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart E that apply to CalOptima or DHCS, as applicable, in the performance of such obligation.

14. **Access to Practices, Books and Records**. Business Associate shall make its internal practices, books, and records relating to the Use and disclosure of PHI on behalf of CalOptima available to CalOptima upon reasonable request, and to the DHCS and the Secretary for purposes of determining CalOptima's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI on behalf of CalOptima available to DHCS, CalOptima, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, CMIA, and implementing regulations. Business Associate shall immediately notify CalOptima of any requests made by DHCS or the Secretary and provide CalOptima with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima or, if agreed to by CalOptima, destroy all PHI and other Confidential Information received from, or created or received by Business Associate on behalf of, CalOptima that Business Associate or its Agents still maintains in any form, and shall retain no copies of such information. If CalOptima elects destruction of PHI and/or other Confidential Information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15.1 and 15.2 below and shall certify in writing to CalOptima that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima of the conditions that make the return or destruction infeasible. Subject to the approval of CalOptima's

regulator(s) if necessary, if such return or destruction is not feasible, CalOptima shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

15.1 **Data Destruction**. Data destruction methods for CalOptima PHI or Confidential Information must conform to the NIST Special Publication 800-88. Other methods require prior written permission of CalOptima and, if necessary, CalOptima's regulator(s).

15.2 **Destruction of Hard Copy Confidential Data**. CalOptima PHI or Confidential Information in hard copy form must be disposed of through confidential means, such as cross cut shredding and pulverizing.

16. **Special Provision for SSA Data**. If Business Associate receives data from or on behalf of CalOptima that was verified by or provided by the Social Security Administration ("**SSA Data**") and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by CalOptima, a list of all employees and Agents and employees who have access to such SSA Data, including employees and Agents of its Agents, to CalOptima.

17. **Breaches and Security Incidents**. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any Breach or Security Incident, and take the following steps:

17.1. **Notice to CalOptima**

17.1.1. **Immediate Notice**. Business Associate shall notify CalOptima immediately upon the discovery of a suspected Breach or Security Incident that involves SSA Data. This notification will be provided by email upon discovery of the Breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to CalOptima.

17.1.2. **24-Hour Notice**. Business Associate shall notify CalOptima within 24 hours by email (or by telephone if Business Associate is unable to email CalOptima) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

17.1.2.1. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

17.1.2.2. Any suspected Security Incident which risks unauthorized access to PHI and/or other Confidential Information;

17.1.2.3. Any intrusion or unauthorized access, Use or Disclosure of PHI in violation of this Agreement; or

17.1.2.4. Potential loss of confidential data affecting this Agreement.

17.1.3. Notice shall be provided to the CalOptima Privacy Officer ("**CalOptima Contact**") using the CalOptima Contact Information at Section 17.7 below. Such notification by Business Associate shall comply with CalOptima's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

17.2. **Required Actions**. Upon discovery of a Breach or suspected Security Incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

17.2.1. Prompt action to mitigate any risks or damages involved with the Security Incident or Breach;

17.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

17.2.3. Any corrective actions required by CalOptima or CalOptima's regulator(s).

17.3. **Investigation**. Business Associate shall immediately investigate such Security Incident or confidential Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting such privacy incident.

17.3.1. Incident details including the date of the incident and when it was discovered;

17.3.2. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;

17.3.3. The nature of the data elements involved and the extent of the data involved in the Breach;

17.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

17.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

17.3.6. A description of the probable causes of the improper Use or Disclosure;

17.3.7. Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);

17.3.8. Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured PHI;

17.3.9. Whether a law enforcement official has requested a delay in notification of Individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or Confidential Information because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

17.3.10. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

17.4. **Complete Report**. Business Associate shall provide a complete written report of the investigation ("Final Report") to the CalOptima Contact within seven (7) working days of the discovery of the

Security Incident or Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting of such privacy incident.

17.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17.3 above and the following:

17.4.1.1. An assessment of all known factors relevant to a determination of whether a Breach occurred under HIPAA and other applicable federal and state laws;

17.4.1.2. A full, detailed corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future, including its implementation date and information on mitigation measures taken to halt and/or contain the improper Use or Disclosure and to reduce the harmful effects of the Breach. All corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s), as applicable; and

17.4.1.3. The potential impacts of the incident, such as potential misuse of data and identity theft.

17.4.2. If CalOptima or CalOptima's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

17.4.3. CalOptima and CalOptima's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a Breach occurred, whether the Security Incident or Breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

17.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17.4 above, Business Associate shall request approval from CalOptima within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima and, if necessary, CalOptima's regulator(s).

17.5. **Notification of Individuals**. If the cause of a Breach is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify Individuals accordingly and pay all costs of such notifications, as well as costs associated with the Breach. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with CalOptima. CalOptima and CalOptima regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima and CalOptima regulator(s), as applicable, must be obtained before the notifications are made.

17.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima**. If the cause of a Breach of PHI is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business

Associate agrees that CalOptima shall make all required reporting of the Breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

17.7. **CalOptima Contact Information**. To direct communications to CalOptima Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

CalOptima Privacy Office

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

18. **Responsibilities of CalOptima**

18.1 CalOptima agrees to not request the Business Associate to Use or Disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

18.2 **Notification of SSA Data**. CalOptima shall notify Business Associate if Business Associate receives data that is SSA Data from or on behalf of CalOptima.

19. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima for and hold it harmless from (i) any and all fees and expenses CalOptima incurs in investigating, responding to, and/or mitigating a Breach of PHI or Confidential Information caused by Business Associate or its Agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima due to a claim, lawsuit, or demand by a third party arising out of a Breach of PHI or Confidential Information caused by Business Associate or its Agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima by any government agency/regulator based on a Breach of PHI or Confidential Information caused by Business Associate or its Agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of Breach to Individuals and regulators, and required reporting of Breach. Acceptance by CalOptima of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima and/or CalOptima's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the CalOptima Privacy Officer in writing. Whether or how CalOptima or CalOptima's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2. If Business Associate is the subject of an audit, compliance review, investigation or any

proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify CalOptima unless it is legally prohibited from doing so.

21. **Term and Termination**

21.1 **Term**. This exhibit is effective as of the Effective Date and shall terminate when (i) the Services Agreement terminates, (ii) in accordance with this Section 21, or (iii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 15.

21.2. **Termination for Cause**. Upon CalOptima's knowledge of a violation of this Agreement by Business Associate, CalOptima may in its discretion:

21.2.1. Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by CalOptima; or

21.2.2. Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.3. **Judicial or Administrative Proceedings**. CalOptima may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. **Miscellaneous Provisions**

22.1. **Disclaimer**. CalOptima makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other Confidential Information.

22.2. **Amendment**

22.2.1. Any provision of this Agreement which is in conflict with current or future applicable federal or state laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2. Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3. **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and Agents available to CalOptima or CalOptima's regulator(s) at no cost to CalOptima or CalOptima's regulator(s), as applicable, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CalOptima or

CalOptima's regulator(s), their respective directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4. **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5. **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6. **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

22.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

22.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or Confidential Information by Business Associate or any agent, subcontractor, employee or third party that received PHI or Confidential Information, and Business Associate agrees that CalOptima may seek injunctive relief under this section without any requirement to prove actual monetary damage or post a bond or other security.

22.9 **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of CalOptima's contracts with regulator(s) or any other monitoring requests by CalOptima's regulator(s).

[SIGNATURES ON FOLLOWING PAGE]

EXECUTION

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima, this Business Associate Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate	CalOptima
______________________	______________________
Print Name	Print Name
______________________	______________________
Signature	Signature
______________________	______________________
Title	Title
______________________	______________________
Date	Date
______________________	______________________
Print Name	Print Name
______________________	______________________
Signature	Signature
______________________	______________________
Title	Title
______________________	______________________
Date	Date

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
16. Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
1. Authorize reallocation of remaining unspent funds, approximately $1.0 million, from the Board-approved initiative CalOptima Health 2023 Member Health Needs Assessment (MHNA) to fund the 2024 Member and Population Health Needs Assessment (MPHNA).
2. Approve the scope of work (SOW) for the 2024 CalOptima Health MPHNA and release of a request for proposals (RFP).

Background
In 2018, CalOptima Health conducted a Member Health Needs Assessment (MHNA) to identify the focused needs of Orange County's Medi-Cal beneficiaries, in particular to assess the health needs and preferences of diverse populations. The results of the 2018 assessment highlighted key findings in the areas of:

- Social Determinants of Health,
- Mental Health,
- Primary Care,
- Provider Access, and
- Dental Care.

On November 3, 2022, the CalOptima Health Board of Directors (Board) approved $1 million from reserves to fund the CalOptima Health 2023 MHNA to conduct an expanded and refreshed assessment and to take into account the needs of members after the COVID-19 pandemic. CalOptima Health released an RFP for consultant services on November 8, 2022, and the evaluation committee selected Harder + Company Community Research (Harder + Company) to conduct the assessment. On February 2, 2023, the Board approved the contract with Harder + Company in an amount not to exceed $1,250,000 and appropriated up to $250,000 from reserves to fund the shortfall. The contract was to assess and support the following areas:

- Implementing Department of Health Care Services (DHCS) population health strategies (*e.g.*, population health management strategy, support health and opportunity for children and families, comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (now referred to as Medi-Cal Transformation) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.

- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by the COVID-19 pandemic and identifying sustainable solutions.

Following approval of the Harder + Company contract in 2023, new regulatory and accreditation requirements from DHCS and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. As CalOptima Health began working with Harder + Company, CalOptima Health staff discovered that these new requirements were not accounted for in the Board approved SOW and contract. Based on the new changes to regulatory and accreditation requirements, CalOptima Health staff chose to end the Harder + Company contract in January 2024 and develop a new SOW and project approach.

Discussion

Given the changes to regulatory requirements under Medi-Cal Transformation and NCQA accreditation requirements, staff recommends Board approval of the new SOW and release of an RFP to procure the services of a research consultant with knowledge of Orange County's diverse populations and opportunities for meaningful outreach and engagement to conduct the 2024 MPHNA. The new MPHNA will be a more comprehensive assessment and will be expanded to help CalOptima Health assess whole-person health needs and identify additional barriers to access to care, gaps in services, and disparities in health among members and the general community. The 2024 MPHNA will utilize existing CalOptima Health member data, existing community data provided by the county Community Health Needs Assessment, and other sources of data. The 2024 MPHNA may also utilize a small member survey and member focus groups to obtain member input.

There is approximately $1.0 million in unspent funds available for reallocation after the termination of the Harder + Company contract. Staff recommends reallocation of the remaining funds to support the CalOptima Health 2024 MPHNA. If approved, CalOptima Health will issue an RFP for consultant services for the new SOW. Proposals received will be evaluated by an evaluation committee. Upon completion of the RFP process, staff will make a recommendation for selection of a vendor to the Board at a future Board meeting.

Fiscal Impact

Previous Board actions on November 3, 2022, and February 2, 2023, authorized $1.25 million to fund the CalOptima Health 2023 MHNA. The remaining unspent funds of approximately $1.0 million committed for this Board-approved initiative will fund the CalOptima Health 2024 MPHNA.

Rationale for Recommendation

Approving the recommended actions will allow CalOptima Health to move forward with a new SOW and obtain a contractor that can support all regulatory and accreditation requirements for member and population assessment.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member and Population Health Needs Assessment (MPHNA) 2024 Scope of Work.
2. Previous Board Action November 3, 2022, "Approve Actions Related to CalOptima Health Member Health Needs Assessment 2023."
3. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

SCOPE OF WORK
CalOptima Health Member and Population Health Needs Assessment

I. OBJECTIVE

CalOptima Health is seeking a contractor to conduct a comprehensive Member and Population Health Needs Assessment (MPHNA). The purpose of the MPHNA is to:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

II. SCOPE OF WORK

CalOptima Health seeks a contractor to provide professional research and analytical services that has detailed knowledge of Medi-Cal, Medicare, and Orange County populations. The contractor shall have demonstrated expertise and knowledge in analyzing population and member level data and producing detailed analyses and dashboards to present study findings. The contractor shall be able to analyze existing CalOptima Health and community data sources and also propose approaches to obtaining member, provider, and community input through interviews, surveys and/or focus groups.

Consulting services will be for the purpose of taking a strategic approach to consolidating related CalOptima Health efforts to assess population health data (including members and potential members) that meets deliverable requirements as outlined by the Department of Health Care Services (DHCS), NCQA, and other related requirements. These contracted services will inform and support CalOptima Health in achieving the following objectives:

- Meet the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, Population Needs Assessment (PNA), and Medi-Cal Transformation initiatives.
- Meet the requirements of NCQA Health Plan Accreditation PHM Standards, PHM 2, including Elements A (Data Integration), B (Population Assessment), and D (Segmentation).
- Meet the requirements of NCQA Health Equity Accreditation as applicable.
- Understand the detailed member and population needs of our member population and community, including in the domains outlined in this scope of work.

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- Understand member experience with CalOptima Health services and recommendations for future service offerings.
- Identify opportunities to advance health equity with our member population.

The MPHNA areas of assessment will include *but not be limited to* the attributes/domains of the CalOptima Health member population as outlined in the table below. CalOptima Health aims to assess these areas for our entire member population as well as for subsets of the member population, including child and adolescent members, members with disabilities, members with serious mental illness or serious emotional disturbance, members of racial or ethnic groups, members with limited English proficiency, and other relevant subpopulations.

Assessment Domain	Areas for Analysis
Demographics of Member Population	• Age • Race • Ethnicity • Language • Sexual Orientation • Gender Identity • Etc.
Health Status and Health Conditions	• Chronic conditions/disease prevalence (e.g., asthma, diabetes, chronic obstructive pulmonary disease, etc.) • Member risk profile • Births • High-risk pregnancy • Behavioral health conditions • Smoking • Substance use disorder • Disparities • Vaccination rates • Select Healthcare Effectiveness Data and Information Set (HEDIS) measures
Social Conditions	• Social determinants of health needs • Barriers to getting needed help • Barriers to economic mobility • Transportation challenges • Etc.
Health Equity	• Challenges with accessing care (e.g., language, health literacy, affinity with providers, etc.) • Challenges with accessing social supports • Member experience • Cultural preferences

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Assessment Domain	Areas for Analysis
Access to Care and Supports	• Barriers to accessing care and support (e.g., childcare, hours of operation, not enough information, unable to find a provider, no appointments available/delays in timely access, etc.) • Access to behavioral health services and barriers • Services most and least utilized • Unmet care needs • Eligibility loss/churn/income changes
CalOptima Health Services & Supports	• Experience with CalAIM services • Medicare supplemental benefits • Participation in other coverage programs • How CalOptima Health partners in their communities

The project shall incorporate coordination and collaboration with CalOptima Health and external partners (e.g., Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

III. CONSULTANT/CONTRACTOR'S RESPONSIBILITIES

Consultant/Contractor shall:

1. Develop a study design to identify, synthesize, and analyze all available data to assess member health and population needs, including but not limited to:
   a. CalOptima Health internal data
   b. Additional data sources, i.e., the county Community Health Needs Assessment, etc.
   c. Member input through a small-scale member survey to fill gaps in existing data, focus groups, etc.
   d. Community input
   e. Provider input

   The Study design must outline study methodologies, data sources, and data collection methods. The study design must be presented to CalOptima Health for review and input prior to finalization. It will also be presented to the CalOptima Health Member and Provider Advisory Committee and potentially other community forums for comment.

2. Develop a detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities. The timeline should be developed in partnership with CalOptima Health staff to account for regulatory approval timelines where necessary. The project plan must be updated throughout the project if timelines change.

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3. Develop MPHNA deliverables that will be presented to CalOptima Health for review and approval, including if applicable:
    a. Final survey instruments (e.g., member, provider, key informant)
    b. Focus group facilitation guides, presentations, and other relevant materials
    c. Outreach and engagement materials for member communication and community organization communication

   All member facing materials must be translated in all threshold languages. All member facing materials must also be submitted for review to CalOptima Health. CalOptima Health may be required to submit certain materials to the Department of Health Care Services for review and approval, and timelines should be constructed to allow such approval time.

4. Facilitate member outreach and engagement activities in threshold languages in partnership with CalOptima Health and community organizations (e.g. member incentives, focus groups, community, or member forums, etc.) as needed to support the approved study design.

5. Provide interim assessment deliverables for NCQA filings if needed. These interim deliverables may include a preliminary assessment of internal and secondary data sources and obtaining member input from existing member committees and forums.

6. Develop final MPHNA report and executive summary presentation to CalOptima Health and its leadership detailing assessment findings and recommendations.

7. Produce dashboard for member assessment that can be utilized by CalOptima Health staff and stakeholders for ongoing population needs assessment reporting.

8. Deliver data set collected and synthesized through the conduct of the assessment study.

9. Schedule and conduct regular meetings with CalOptima Health staff to present relevant findings and project status.

10. Present MPHNA findings to the CalOptima Health Board of Directors.

The Consultant/Contractor must perform all work according to industry and professional standards and in a manner satisfactory to CalOptima Health and, if applicable, regulatory and accreditation requirements.

The Consultant/Contractor may propose to utilize subcontracted services for survey administration and/or focus group facilitation to ensure alignment of skills with services. The Consultant/Contractor is responsible for ensuring that performance and completion of project deliverables by any and all subcontractors align with the responsibilities outlined in this scope of work.

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IV. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health staff shall:

1. Provide a point of contact and meet regularly with the Consultant/Contractor to discuss project status, open questions, and deliverable development.
2. Provide documentation on requirements for Consultant/Contractor to review and key resources and department point of contacts.
3. Provide guidance on regulatory and CalOptima Health's requirements.
4. Work collaboratively with Consultant/Contractor to promote member and provider surveys, if included in the study design.
5. Provide and distribute Member Incentives (if applicable).
6. Utilize existing community relationships to make introductions for the Consultant/Contractor to connect with these organizations.
7. Facilitate CalOptima Health internal approvals and DHCS regulatory approvals as needed.
8. Provide Consultant/Contractor with points of contact to administer community leader/key informant and provider interviews (if applicable).

V. TIMELINES

This contract will continue through the completion of deliverables outlined in the Scope of Work, with a framework that can be leveraged for annual refreshing on a go-forward basis of the MPHNA to meet NCQA requirements. Consultant/Contractor shall:

1. Begin project planning in July 2024, with implementation through December 2024.
2. On an ongoing basis, meet regularly with CalOptima Health to assess progress and opportunities and share findings with CalOptima Health.

VI. PRICING

The Consultant/Contractor should propose a budget and pricing for this project.

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CalOptima Health Board Action Agenda Referral

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

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn   *10/27/2022*
Authorized Signature   **Date**

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. <u>Member Incentives</u>

1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions
1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background
In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

CalOptima Health Board Action Agenda Referral

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

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.

- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:
- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. **SCOPE OF WORK**

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. <u>Member Incentives</u>
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. <u>Member Health Needs Assessment 2023 Report and Executive Summary</u>
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

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

Report Item
17. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

Contact
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions
1. Approve CalOptima Health staff to administer and execute 15 grant agreements and award payments totaling up to $16,417,044 for 13 selected grant recipients (listed in Attachment 2) for the first round of community grants in the CalOptima Health Comprehensive Community Cancer Screening and Support Program.
2. Approve an allocation of $1,417,044 from the remaining balance of $15.0 million for the second round of community grants in the CalOptima Health Comprehensive Community Cancer Screening and Support Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
In December 2022, the CalOptima Health Board (Board) approved the Comprehensive Community Cancer Screening and Support Program (Program) with a reallocation from Intergovernmental Transfer (IGT) 9 funds and an allocation from IGT 10 funds not to exceed $50.1 million, in aggregate, over five years. The goals of the Program are to decrease late-stage cancer diagnosis rates, increase early detection through improved awareness and access to cancer screening, and improve quality and member experience during cancer screening and treatment among Medi-Cal members for breast, cervical, colon, and lung cancer (in certain smokers).

As part of the program, in November 2023, the Board approved a $5.3 million Comprehensive Cancer Screening Awareness and Education Campaign over four years to develop and launch a multimedia, multilingual campaign that ensures a unified and clear message is spread across all residents of Orange County, including CalOptima Health members. The campaign discovery phase launched in January 2024 with stakeholder input sessions held between February and April 2024. Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged in development of creative concepts for an anticipated soft launch in Fall 2024.

From January to December 2023, as part of the overall Program development, CalOptima Health engaged community stakeholders such as the University of California, Irvine Chao Family Comprehensive Cancer Center, Orange County Cancer Coalition (comprised of 19 organizations), and the Coalition of Orange County Community Health Centers. Stakeholders highlighted barriers to improving cancer awareness, screening access, and member experience throughout cancer treatment.

In February 2024, based on stakeholder input, data analysis, and a review of research and best practices, CalOptima Health staff proposed, and the Board approved, five program initiatives: (i)

Community Grants, (ii) Orange County Cancer Screening and Support Collaborative, (iii) Vendor Contracts to Support the Member Journey, (iv) Program Research and Evaluation, and (v) Internal Program Support. The five program initiatives were estimated to cost a total of $44.7 million and utilize the remaining balance of the Program.

Under the aforementioned Community Grants program initiative, the Board approved up to $30 million across two rounds of competitive grants (or $15.0 million for each round). Following Board approval, CalOptima Health staff developed and released the first notice of funding opportunity (NOFO) to support screening activities, which may include costs for capacity building, infrastructure and capital improvements, and care coordination to increase screening and decrease late-stage discovery. The second NOFO would be developed and released in the future to build upon best practices and/or priorities emerging from the first round of grants.

Discussion

The NOFO for the first round of community grants was released to the public on February 7, 2024, via email distribution lists, press release, and CalOptima Health's website. CalOptima Health staff facilitated a question-and-answer (Q&A) session describing the grant application process, funding categories, and applicant eligibility criteria and responded to questions. The Q&A presentation and a frequently asked questions document were posted on the CalOptima Health website. The application period opened immediately following the Q&A session and remained open until March 29, 2024.

CalOptima Health conducted a rigorous review of 27 proposals received from 22 organizations totaling $31,677,052, exceeding the $15 million allocated for this round of funding. An internal committee of CalOptima Health representatives from Medical Management, Equity and Community Health, Case Management, and Quality Analytics departments reviewed and scored the submitted proposals. Evaluation criteria used in the grant review consisted of alignment with the Program objectives, core mission and value alignment, ability to decrease late-stage cancer diagnosis, health equity, project implementation, budget and financial management, and project readiness. Fifteen proposals scored at least 80 points out of a possible 100 points and received recommendations for full or partial funding. To fund the highest-scoring proposals and deliver culturally tailored cancer screening services for CalOptima Health members, staff recommend reallocating $1,417,044 from Round 2 to Round 1 NOFO funding. After reallocation, total funding for Round 1 will be $16,417,044 and Round 2 will be $13,582,956. The total allocation for the Community Grants program initiative will remain at $30 million as the Board previously approved.

Staff will provide oversight of the grants in accordance with CalOptima Health Policy AA.1400: Grant Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact

The recommended action is funded by a previous Board-approved allocation of $30 million for the Community Grants program initiative at the February 1, 2024, CalOptima Health Board of Directors meeting. This action has no additional fiscal impact.

CalOptima Health reserves the right to adjust or recoup funds for lack of demonstrating effort and performance against targeted measures.

Rationale for Recommendation

CalOptima Health is committed to improving cancer screening rates, health outcomes, and member experience. Approving the recommended actions will support improvement of cancer screenings, early cancer diagnosis, and treatment for CalOptima Health members. Staff will bring additional recommendations to the Board for review and approval in the future, including a NOFO and direct contracts for research and evaluation and vendor services to support the member journey.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Applicants - Scores and Funding Recommendation
3. Presentation of NOFO Process and Funding Recommendations
4. CalOptima Health Policy AA.1400: Grant Management

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members	5 Years	$50.1 million
February 1, 2024	Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives and Actions to Develop and Release a Notice of Funding Opportunity	2 Years	$15 million (from the previously Board-allocated $50.1 million)

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Back to Agenda

Attachment to the August 1, 2024, Board of Directors Meeting – Agenda Item 17

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
American Cancer Society, Inc.	270 Peachtree Street, Suite 1300	Atlanta	GA	30303
Celebrating Life Community Health Center	27800 Medical Center Road, Suite 110	Mission Viejo	CA	92691
Families Together of Orange County	661 W. 1st Street	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St	La Habra	CA	90631
Hurtt Family Health Clinic	14642 Newport Ave, Suite 300	Tustin	CA	92780
Korean Community Services	451 W Lincoln Ave.	Anaheim	CA	92805
Laguna Beach Community Health Center	362 Third Street	Laguna Beach	CA	92656
Latino Health Access	405 W. 4th Street	Santa Ana	CA	92701
mPulse	21255 Burbank Blvd	Los Angeles	CA	91369
Share Ourselves	20151 SW Birch Street, Suite 100	Newport Beach	CA	92660
The G.R.E.E.N Foundation	2030 E. Fourth Street, Suite D213	Santa Ana	CA	92705
UCI Family Health Center	800 N. Main Street	Santa Ana	CA	92701

Attachment to the August 1, 2024 Board of Directors Meeting – Agenda Item 17

CalOptima Health Comprehensive Community Cancer Screening and Support Community Grants – Applicants' Scores and Funding Recommendation

Applications that scored 80 points and above through the competitive scoring process are recommended for a grant award.

Organization	Proposal Description	Score	Requested Amount	Funding Amount
Korean Community Services (KCS)	Incorporate medical providers from KCS and Southland Integrated Services alongside patient navigators from Orange County Asian Pacific Islander Community Alliance, The Cambodian Family, and Vietnamese American Cancer Foundation, to facilitate direct pathways from outreach to clinical service.	92	$3,900,072	$ 3,000,000
AltaMed Health Services Corporation (App. # 1)	Increase the effectiveness and efficiency of AltaMed's cancer screening programs in Orange County by: 1) Optimizing navigation support services for patients who are screened for cervical and lung cancer; and 2) Launching a pilot program for lung cancer screening that will support quality of care, follow-up, treatment and direct patient navigation.	89	$3,454,336	$1,499,992
Celebrating Life Community Health Center (App. #2)	Develop and implement a communication campaign to reach all target demographics; provide community-oriented outreach incorporating lived experience and/or topic expertise; incorporate cancer risk assessments; and strengthen workforce to increase access to equitable and culturally-competent health care services.	89	$1,290,575	$1,290,575
mPulse	Improve general awareness of cancer prevention, increase breast, cervical, colorectal, and lung cancer screening rates, and support members facing cancer through equitable and targeted two-way SMS programs. This program will be designed to identify health action barriers at the individual level and provide tailored/actionable information.	87	$1,197,625	$1,197,625
UCI Family Health Center	In partnership with American Cancer Society and UCI Chao Cancer Institute, improve the rates of breast, cervical, and colorectal cancer screenings	87	$1,541,298	$1,500,000

	and strengthen relationships with imaging and cancer centers to ensure timely screening and follow up; hire additional staff to support expansion of services; and leverage technology to provide timely reminders and linkages to screenings.			
Hurtt Family Health Clinic	Expand patient navigation services, implement a comprehensive outreach strategy, standardized workflows and protocols for Universal Screening, and establish data-driven clinical workflows to optimize patient care and outcomes related to cancer screening and treatment.	85	$ 1,018,600	$ 1,018,600
Laguna Beach Community Health Center	Conduct outreach and education to increase cancer screening among CalOptima Health Members. In addition, LBCC will provide patient navigation and resource support to promote treatment compliance.	84	$116,000	$116,000
AltaMed Health Services Corporation (App. # 2)	Provide outreach and education, encourage timely screening, and provide care navigation support to patients from screening through diagnosis and treatment. In addition, AltaMed plans to enhance electronic health record to improve systems and workflow from screening through diagnosis and treatment.	83	$752,349	$752,349
Friends of Family Health Center (App. # 1)	Expand its Women's Health Program by incorporating on-site mammography services. FOFHC plans to recruit and hire, trained and certified staff to oversee and operate the mammography services offered.	83	$554,875	$554,875
Share Ourselves	Recruit Manager of Population Health and Quality Improvement and Population Health Coordinator to strengthen their breast, cervical, and colorectal cancer screening program. This program will focus on cancer screening, outreach, education, care coordination, and patients access to social support and health services.	83	$362,500	$362,500
Families Together of Orange County (App. # 2)	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1)-Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 2) Partnering with at least two organizations serving communities of focus to increase access to cancer screening; 3) Conducting community outreach campaigns, increasing social media/marketing efforts and providing educational workshops to raise awareness of services and screening programs.	82	$3,832,437	$1,500,000
Celebrating Life Community Health Center (App. # 1)	Identify a team-based approach using providers and health information technology to increase awareness, conduct a risk assessment, and complete preventative cancer screenings. This approach also includes the implementation of IT	81	$329,428	$329,428

	solutions to improve population health, data integration, and ease reporting.			
Latino Health Access	Expand Community Health Worker services by recruiting and training a group of promotores to provide breast, cervical, colorectal and lung cancer screening education, navigation, and peer support services and expand partnerships to address barriers to screening access and treatment.	81	$2,255,296	$1,500,000
The G.R.E.E.N Foundation	Bolster cancer prevention education, early detection, treatment, and social support for African American and Black Medi-Cal members. Through tailored approaches, addressing members' concerns and raise their confidence in CalOptima Health's commitment to equitable care to help foster stronger relationships with primary care efforts.	81	$295,100	$295,100
American Cancer Society, Inc.	Increase community outreach, education, and patient service offerings in Orange County and to amplify work with OC health systems to improve enduring adherence to cancer screening guidelines and provide optimal cancer care.	80	$2,011,728	$1,500,000
Vista Community Clinic	Hire and train a Cancer Screening Navigator to identify patients eligible for and in need of colorectal, breast, and/or cervical cancer screening services and provide education on the importance and periodicities of screenings, promote completion of screenings, and assist patients in need of follow-up care. Patient education project staff will develop two videos (one in Spanish, one in English) to share with patients via text, email, and in-clinic screenings.	78	$207,956	0
Serve the People Community Health Center	Launch the ScreenSmart program which uses a combination of outreach efforts, community engagement, and accessible screening services to empower women to take control of their health and prioritize preventive care. ScreenSmart strives to reduce the incidence of breast and cervical cancer among CalOptima Health Members, ultimately saving lives and improving the overall well-being of women in our communities and populations of color.	78	$864,912	0
Families Together of Orange County (App. # 3)	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1) Developing educational, social media and marketing materials informed by local cancer coalitions and committees; 2) Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 3) Partnering with at least two organizations serving	76	$514,794	0

	communities of focus to increase access to cancer screenings by 10% in Year 1 and 5% in Year 2.			
Planned Parenthood of Orange and San Bernardino Counties - Melody Health	Strengthen Planned Parenthood's electronic medical record system to enhance population-based interventions to reduce late-stage cancer diagnosis. In addition, this project aims to enhance infrastructure capacity to allow automation and streamline workflows to increase patient access, outreach, and linkages to care that will reduce late-stage cancer diagnoses.	71	$1,845,010	0
Friends of Family Health Center (App. #2)	Proposed program includes: (1) Content marketing campaign focused on saving lives through preventative cancer screenings; (2) Community Health Workers and Promatores to provide direct outreach within our target communities; (3) Increase provider and patient navigator support to accommodate patients accessing preventative cancer screenings.	71	$837,142	0
Cancer Kinship	Hire a fulltime Licensed Clinical Social Worker, a Community Health Worker, a Client Services Specialist, and a Program Measurement Administrator to expand program and prioritize educating CalOptima Health members and eligible individuals on cancer screenings, survivorship vigilance, family risks, and to connect them with critical community resources through navigation services. Expand outreach efforts, with a specific focus on the Latino population.	69	$943,294	0
North Orange County Regional Foundation	Launch the VitalCheck Mobile Screening Program to increase the rate of cancer screening and improve cancer outcomes for homeless community and CalOptima members. VitalCheck will use Care Guides to educate patients on the importance of preventive screening, identify barriers, and facilitate access to follow-up diagnostic testing and treatment. VitalCheck will also use a Mobile Medical Clinic as a screening setting at three homeless service sites providing a total of six screening events per month.	69	$1,098,467	0
Families Together of Orange County (App. #1)	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1) Developing educational, social media and marketing materials informed by local cancer coalitions and committees; 2) Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 3) Increasing the functionality of the electronic health records system and billing department capacity to improve the exchange of information between FTOC and Lestonnac Free Clinic.	68	$110,000	0

Camino Health Center	Improve member experience by purchasing a two-way text messaging platform to generate data reports that will identify patients past due for preventive cancer screenings; disseminate tailored messages to patients due; and send education text campaigns on a quarterly basis. Hire more staff to engage in patient education via the text messaging platform, conduct telephonic appointment reminders, provide education, and recommend suitable testing.	65	$500,000	0
Asian American Senior Citizens Service Center	Launch the CARES Program to raise awareness, improve access to screenings, and provide vital support to affected individuals through educational outreach, accessible screenings, and emotional support networks to empower communities.	59	$493,258	0
Southern California Youth Engagement Association	Use targeted outreach, culturally tailored educational materials, and community-based screening events to empower individuals with the knowledge and resources necessary to navigate their healthcare proactively. Special emphasis will be placed on hiring bilingual patient navigators to provide personalized guidance, from understanding one's risk to navigating the screening process and follow-up care.	51	$100,000	0
Ashtrix inc.	Deploy HealthGuard AI, a patient portal to build detailed patient profiles that can enhance understanding of each patient's care continuum, including social determinants of health (SDOH) and longitudinal health history. Ashtrix aims to empower patients with tailored information and tools needed to adhere to timely cancer screenings and diagnostics.	0	$1,250,000	0

Comprehensive Community Cancer Screening and Support Program – NOFO Round 1 Recommended Grantees

August 1, 2024

Richard Pitts, D.O., Ph.D., Chief Medical Officer

Our Mission

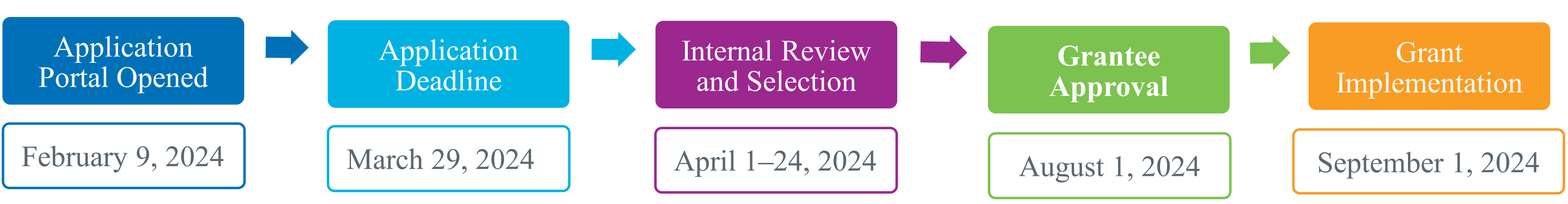
To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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

Notice of Funding Opportunity (NOFO)

- Up to **$16,417,044** in grant funding to support activities related to capacity building, infrastructure and capital improvements, and care coordination collaboratives.
- Grants are intended to improve services and supports for Medi-Cal members and at minimum result in the following outcomes:
  - Increase community and member cancer awareness and engagement.
  - Increase access and utilization of cancer screening services.
  - Decrease late-stage cancer discovery.
  - Improve member experience throughout cancer treatment.



Dates subject to change.

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Applications Received

- Received 27 applications from 22 unique organizations totaling **$31,677,052** million that spanned the identified funding categories and county.

Funding Categories	Number of Applications	Total Funds Requested
Capacity Building	16	$20,008,357
Care Coordination Collaboratives	4	$5,728,566
Infrastructure and Capital Improvements	7	$5,940,129
Total	**27**	**$31,677,052**

Review Process

- A committee of nine internal staff reviewed, scored and selected the top-scoring applicants.
- Reviewers were selected based on three areas of expertise:
  - Cancer screening program awareness
  - Clinical and quality context
  - Community and equity context
- Each proposal was reviewed and scored on its own merit.
- Proposals were rated on seven criteria identified and published on the NOFO.
- Geographic coverage, location, racial/ethnic population and cancer types were considered when deciding between applicants with similar scope and score.

Evaluation Criteria

Criterion	Maximum Points	Description of Basis for Assigning Points
Alignment with program	Yes/No	• Project aligns with the program goals to increase awareness and access to cancer screening, decrease late-stage cancer diagnosis, and/or improve quality and member experience during cancer screening and treatment procedures.
CalOptima Health's core mission and value alignment	20	• Project improves member health outcomes by addressing health disparities, removing barriers to access, and providing opportunities for more CalOptima Health members to be treated with excellence and dignity.
Decrease late-stage cancer diagnosis	20	• Project demonstrates ability to increase screening as a means to decrease late–stage cancer diagnosis.
Equity	20	• Applicant describes how they will identify and tailor grant activities to meet the needs of the Medi-Cal populations most impacted by cancer.
Project Implementation	20	• Project plan is complete, incorporates evidence-based practices, and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success.
Budget and Financial Management	10	• Project budget is sound and provides details on program plan. • Able to demonstrate strong financial management capacity.
Capacity and Project Readiness	10	• Applicant demonstrates experience in developing programs and interventions for Medi-Cal populations in Orange County. • Projects can be launched soon after the grant award.
Total Possible Points	**100**	

Award Recommendations

- Applications that scored 80 points and above through the competitive scoring process are recommended for a grant award.
- To ensure equitable distribution of funds, review committee recommended:
  - A maximum grant award of $3 million per organization.
  - One grant per category, not to exceed two grants per organization.
  - Maximum allocation per organization by category:
    - Capacity Building: $1.5 million
    - Care Coordination Collaboratives: $3 million
    - Infrastructure/Capital Improvements: $1 million
- Grant awards are recommended for 15 applications from 13 organizations based on the competitive scoring process and maximum grant award amount.

Recommended Grant Awards

Organization Name	Score	Requested Amount	Recommended Award
Korean Community Services (KCS)	92	$3,900,072	$3,000,000
AltaMed Health Services Corporation (Application # 1)	89	$3,454,336	$1,499,992
Celebrating Life Community Health Center (Application # 2)	89	$1,290,575	$1,290,575
mPulse	87	$1,197,625	$1,197,625
UCI Family Health Center	87	$1,541,298	$1,500,000
Hurtt Family Health Clinic	85	$1,018,600	$1,018,600
Laguna Beach Community Health Center	84	$116,000	$116,000
AltaMed Health Services Corporation (Application # 2)	83	$752,349	$752,349
Friends of Family Health Center (Application # 1)	83	$554,875	$554,875
Share Ourselves	83	$362,500	$362,500
Families Together of Orange County (Application # 2)	82	$3,832,437	$1,500,000
Celebrating Life Community Health Center (Application # 1)	81	$329,428	$329,428
Latino Health Access	81	$2,255,296	$1,500,000
The G.R.E.E.N Foundation	81	$295,100	$295,100
American Cancer Society, Inc.	80	$2,011,728	$1,500,000

Applications Not Recommended for Funding

Organization Name	Proposed Program Title
Vista Community Clinic	Improving Cancer Screening and Follow-up in North Orange County
Serve the People Community Health Center	ScreenSmart: Cancer Prevention Program
Families Together of Orange County (Application # 3)	C3 Health Initiative: Cervical, Colorectal and Breast Cancer Screening Program-Care Coordination Collaboratives
Planned Parenthood of Orange and San Bernardino Counties - Melody Health	Increasing early-stage cancer diagnosis across the community through Infrastructure and Capital Improvements
Friends of Family Health Center (Application # 2)	FOFHC - Closing the Gaps in CCS
Cancer Kinship	From Screening to Survivorship: Cancer Kinship's Path to Early Detection and Improved Quality of Life for CalOptima Health Members
North Orange County Regional Foundation	The Family Health Matters VitalCheck Mobile Screening Program
Families Together of Orange County (Application # 1)	C3 Health Initiative: Cervical, Colorectal, and Breast Cancer Screening Program-Infrastructure and Capital Improvements
Camino Health Center	Improving Quality of Life through Cancer Screening Opportunities
Asian American Senior Citizens Service Center	Cancer Awareness, Risk, & Educational Support Program
Southern California Youth Engagement Association (SoCalYEA)	Cancer Awareness and Prevention Program for the Asian and Pacific Islander community, Primarily in Chinese, Korean, and Vietnamese.
Ashtrix inc.	Implementing HealthGuard AI for Cancer initiative

* Applications were not recommended for funding based on collective review score of 80 points and below.

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Appendix

Recommended Grant Awards

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Korean Community Services (KCS)	92	$3,900,072	$3,000,000	Incorporate medical providers from KCS and Southland Integrated Services alongside patient navigators from Orange County Asian Pacific Islander Community Alliance, The Cambodian Family, and Vietnamese American Cancer Foundation, to facilitate direct pathways from outreach to clinical service.
AltaMed Health Services Corporation (Application # 1)	89	$3,454,336	$1,499,992	Increase the effectiveness and efficiency of AltaMed's cancer screening programs in Orange County by: 1) Optimizing navigation support services for patients who are screened for cervical and lung cancer; and 2) Launching a pilot program for lung cancer screening that will support quality of care, follow-up, treatment and direct patient navigation.
Celebrating Life Community Health Center (Application # 2)	89	$1,290,575	$1,290,575	Develop and implement a communication campaign to reach all target demographics; provide community-oriented outreach incorporating lived experience and/or topic expertise; incorporate cancer risk assessments; and strengthen workforce to increase access to equitable and culturally-competent health care services.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
mPulse	87	$1,197,625	$1,197,625	Improve general awareness of cancer prevention, increase breast, cervical, colorectal, and lung cancer screening rates, and support members facing cancer through equitable and targeted two-way SMS programs. This program will be designed to identify health action barriers at the individual level and provide tailored/actionable information.
UCI Family Health Center	87	$1,541,298	$1,500,000	In partnership with American Cancer Society and UCI Chao Cancer Institute, improve the rates of breast, cervical, and colorectal cancer screenings and strengthen relationships with imaging and cancer centers to ensure timely screening and follow up; hire additional staff to support expansion of services; and leverage technology to provide timely reminders and linkages to screenings.
Hurtt Family Health Clinic	85	$ 1,018,600	$ 1,018,600	Expand patient navigation services, implement a comprehensive outreach strategy, standardized workflows and protocols for Universal Screening, and establish data-driven clinical workflows to optimize patient care and outcomes related to cancer screening and treatment.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Laguna Beach Community Health Center	84	$116,000	$116,000	Conduct outreach and education to increase cancer screening among CalOptima Health Members. In addition, LBCC will provide patient navigation and resource support to promote treatment compliance.
AltaMed Health Services Corporation (Application # 2)	83	$752,349	$752,349	Provide outreach and education, encourage timely screening, and provide care navigation support to patients from screening through diagnosis and treatment. In addition, AltaMed plans to enhance electronic health record to improve systems and workflow from screening through diagnosis and treatment.
Friends of Family Health Center (Application # 1)	83	$554,875	$554,875	Expand its Women's Health Program by incorporating on-site mammography services. FOFHC plans to recruit and hire, trained and certified staff to oversee and operate the mammography services offered.
Share Ourselves	83	$362,500	$362,500	Recruit Manager of Population Health and Quality Improvement and Population Health Coordinator to strengthen their breast, cervical, and colorectal cancer screening program. This program will focus on cancer screening, outreach, education, care coordination, and patients access to social support and health services.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Families Together of Orange County (Application # 2)	82	$3,832,437	$1,500,000	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1) Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 2) Partnering with at least two organizations serving communities of focus to increase access to cancer screening; 3) Conducting community outreach campaigns, increasing social media/marketing efforts and providing educational workshops to raise awareness of services and screening programs.
Celebrating Life Community Health Center (Application # 1)	81	$329,428	$329,428	Identify a team-based approach using providers and health information technology to increase awareness, conduct a risk assessment, and complete preventative cancer screenings. This approach also includes the implementation of IT solutions to improve population health, data integration, and ease reporting.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Latino Health Access	81	$2,255,296	$1,500,000	Expand Community Health Worker services by recruiting and training a group of promotores to provide breast, cervical, colorectal and lung cancer screening education, navigation, and peer support services; develop a bilingual cancer education program inclusive of educational material, community curricula, and other tools to increase community awareness; expand partnerships to address barriers to screening access and treatment; and implement *Juntes Contra el Cancer* pilot to increase direct community engagement, linkages to screening, and peer support.
The G.R.E.E.N Foundation	81	$295,100	$295,100	Bolster cancer prevention education, early detection, treatment, and social support for African American and Black Medi-Cal members. Through tailored approaches, addressing members' concerns and raise their confidence in CalOptima Health's commitment to equitable care to help foster stronger relationships with primary care efforts.
American Cancer Society, Inc.	80	$2,011,728	$1,500,000	Increase community outreach, education, and patient service offerings in Orange County and to amplify work with OC health systems to improve enduring adherence to cancer screening guidelines and provide optimal cancer care.

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Policy: AA.1400
Title: **Grant Management**
Department: Strategic Development
Section: Not Applicable

CEO Approval: /s/ Michael Hunn 05/04/2023

Effective Date: 05/04/2023
Revised Date: Not Applicable

Applicable to:
☐ Medi-Cal
☐ OneCare
☐ PACE
☒ Administrative

I. PURPOSE

This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Approach

1. When resources permit, CalOptima Health may designate authorized funds specifically for CalOptima Health Board of Directors (hereinafter, 'Board')-approved Grants to eligible external organizations with the goal of improving the health of CalOptima Health's Members.

2. CalOptima Health shall ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. CalOptima Health shall uphold the following tenets when awarding Grants:

   a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

   b. Each Grant application shall receive a thorough, unbiased evaluation and review including an assessment of organizational experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

   c. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

   d. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

III. PROCEDURE

A. Pre-Award Assessment:

1. Grant objectives shall be in alignment with organizational strategic priorities.

2. Grant outcomes shall improve or address critical needs of CalOptima Health Members.

B. Award Grant: Establishing Goals and Metrics

1. CalOptima Health will work with Grantees to ensure that all Grants have established one or more goals that direct the use of Grant funds.

2. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.

C. Post-Award: Grant Monitoring and Reporting Requirements

1. CalOptima Health Operations department and/or other internal subject matter experts shall monitor a Grantee's compliance and progress towards achieving the goals presented in the Grantee's Proposal by reviewing the Grant Progress Reports.

   a. Unless otherwise specified in the Grant contract, Grantees shall submit semi-annual Grant Progress Reports, detailing Grant activities, along with any required supporting materials.

      i. The format and specific details of the Grant Progress Report shall be mutually agreed upon by CalOptima Health and the Grantee.

   b. The semi-annual Grant Progress Reports may require a breakdown of funding utilization by category as mutually agreed upon by CalOptima Health and the Grantee.

2. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.

3. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.

   a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.

4. As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant contract term for the following actions including, but not limited to:

   a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

   b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, notable successes, implementation challenges, and early lessons learned;

c. Learn of any anticipated requests for scope or budget changes, or no-cost extensions; and

d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantees are not making sufficient progress towards stated goals or are not meeting other Grant contract requirements.

   a. If sufficient progress is not being made toward Grant contract goals and metrics, CalOptima Health will work with Grantees to understand why metrics were not achieved and work with the Grantee to realign metrics if deemed appropriate.

6. CalOptima Health may conduct audits of the Grantee and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

   a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Strategic Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative

IX. GLOSSARY

Term	Definition
Grantee	A recipient of a grant.
Grants	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved grant project.
Member	A beneficiary enrolled in a CalOptima Health program.
Proposal	An application submitted to CalOptima Health used to formally request funding for a specific project.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

CalOptima Health Board Action Agenda Referral

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

Report Item

18. Approve Actions Related to Convening a Steering Committee and Conducting Community Listening Sessions to Explore Joining Covered California

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Donna Laverdiere, Executive Director of Strategic Development, (714) 986-6981

Recommended Actions

1. Authorize the Chief Executive Officer, or designees, to convene a Stakeholder Steering Committee to explore CalOptima Health joining Covered California and provide feedback throughout the regulatory process.
2. Authorize the Chief Executive Officer, or designees, to conduct stakeholder listening sessions and workshops to explore CalOptima Health joining Covered California.

Background/Discussion

The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010. The ACA allowed states to set up their own state-based marketplace or exchange to provide its residents with an avenue to shop for and purchase their health insurance and receive discounts in the form of federal subsidies if eligible.

California was the first state to introduce legislation to create the California Health Benefit Exchange, known as Covered California. In September of 2010, then-Governor Arnold Schwarzenegger signed Assembly Bill 1602, (the "California Patient Protection and Affordable Care Act"), by Assembly Speaker John Perez, and Senate Bill 900, by State Senator Elaine Alquist, into law.

In 2011, because of the signed legislations, the Orange County Board of Supervisors voted to not allow CalOptima to participate in Covered California. This was done through amending the CalOptima county ordinance that specifically prohibited CalOptima's participation in the State Health Care Exchange.

At the May 5, 2022, meeting, the Board had supported CalOptima's participation in Covered California and directed staff to seek an ordinance change from the County of Orange. The CalOptima Health Board of Directors approved joining Covered California in the Strategic Plan at its meeting on June 2, 2022.

CalOptima Health staff recommends convening a steering committee comprised of providers partners and members to explore joining Covered CA. The recent reinstatement of Medi-Cal renewals and existing churn in eligibility for low-income populations compromises continuity of care for members and results in mixed-coverage households with varying provider networks. Entry into Covered California would bridge the coverage gap when members lose Medi-Cal coverage and keep family members in aligned networks at affordable premiums.

The Steering Committee would provide staff with feedback starting in mid-August and continuing throughout the calendar year.

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Additionally, in order to provide a transparent and robust stakeholder engagement process, staff would like to hold community listening sessions on August 14, 2024 and August 29, 2024.

Staff will bring findings and recommendations on next steps no later than the October Board meeting.

Fiscal Impact
There is no immediate fiscal impact to explore CalOptima Health's participation in Covered California Staff will address any additional fiscal impact in separate Board actions.

Rationale for Recommendation
The recommendation action will allow CalOptima Health to solicit broad stakeholder feedback from the exploratory phase and obtain ongoing feedback related to CalOptima Health's participation in Covered California. The feedback will inform Board recommendations on next steps.

Concurrence
Jim Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Steering Committee Seats
2. Previous Board Action dated May 5, 2022 "Direct the Chief Executive Officer to Take Actions to Amend CalOptima's Ordinance to Allow for the Participation in the California Health Benefit Exchange"
3. Previous Board Action dated June 2, 2022 "Adopt Strategic and Tactical Priorities for 2022-2025"

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Covered California Steering Committee (PROPOSED)

1. Hospital Association of Southern California (HASC) Representative
2. Orange County Medical Association (OCMA) Representative
3. Safety Net Hospital Representative
4. Pediatric Hospital Representative
5. Large Health Network Representative
6. Small Health Network Representative
7. Community Clinic Representative
8. Member Advisory Committee Chair
9. Provider Advisory Committee Chair
10. Office of Supervisor Sarmiento
11. Office of Supervisor Chaffee

CalOptima Board Action Agenda Referral

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Direct the Chief Executive Officer to Take Actions to Amend CalOptima's Ordinance to Allow for the Participation in the California Health Benefit Exchange

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Support CalOptima's participation in the California Health Benefit Exchange; and
2. Direct the Chief Executive Officer to seek an ordinance change from the County of Orange to allow CalOptima to participate in the State Health Insurance Exchange, also known as, Covered California.

Background/Discussion

The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010. The ACA allowed states to set up their own state-based marketplace or exchange to provide its residents with an avenue to shop for and purchase their health insurance and receive discounts in the form of federal subsidies if eligible.

California was the first state to introduce legislation to create the California Health Benefit Exchange, known as Covered California. In September of 2010, then-Governor Arnold Schwarzenegger signed Assembly Bill 1602, (the "California Patient Protection and Affordable Care Act"), by Assembly Speaker John Perez, and Senate Bill 900, by State Senator Elaine Alquist, into law.

In 2011, because of the signed legislations, the Orange County Board of Supervisors voted to not allow CalOptima to participate in Covered California. This was done through amending the CalOptima county ordinance that specifically prohibited CalOptima's participation in the State Health Care Exchange.

Staff is seeking approval to allow the Chief Executive Officer to pursue an ordinance amendment at the County of Orange that would allow CalOptima to participate in Covered California. CalOptima's participation in Covered California would substantially benefit the county and CalOptima members for the following four core reasons:

- Reduce churn by providing CalOptima members continuity of care for former Medi-Cal members.
- Improve access by expanding the options to ensure more lives are covered.
- Extend local expertise that amplifies the impact of CalOptima's community focus.
- Bolster the safety net by bringing revenue that can be invested back into community health.

If approved, staff will seek approval to change the CalOptima Ordinance in order to allow participation in Covered California. The Ordinance is governed by the Orange County Board of Supervisors, so consideration of a change by the Board of Supervisors would require two readings:

- First Reading: Tuesday, May 10
- Second Reading: Tuesday, May 24

Following that process, CalOptima would begin work on building internal capabilities for a plan launch in January 2024. Covered California plans have an open enrollment period that begins in fall for annual coverage. Thus, the CalOptima plan would need to be ready to offer in late 2023 for 2024. Individuals can enroll outside of this window if they have certain life events, such as loss of coverage, a move, marriage and other considerations.

Fiscal Impact

There is no immediate fiscal impact to support CalOptima's participation in Covered California and to seek a change to CalOptima's ordinance. Staff will address any additional fiscal impact in separate Board actions.

Rationale for Recommendation

Participation in Covered California will provide CalOptima with greater opportunities to further its mission and serve its programs and members. The requested action will initiate the Ordinance change process.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Marketplace Briefing Sheet
2. May 10, 2022 Board of Supervisors Agenda Item

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

Proposal and Timeline

At the May 5th CalOptima Board of Directors meeting, staff will seek approval to change the CalOptima Ordinance at the Board of Supervisors (BoS) in order to allow CalOptima to participate in Covered California. If approved, the ordinance change at the BoS would require two readings:

- First Reading-Tuesday, May 10th
- Second Reading-Tuesday, May 24th

The benefit to CalOptima and our members is:

- Continuity of care: up to 10,000 people in CA move between Medi-Cal and Covered California each month (pre-pandemic). Participating in the Exchange allows CalOptima to maintain continuity of care for Orange County residents who switch coverage
- Improved access to care
- Increased revenue that will help to support the safety net

Background

Medi-Cal offers low-cost or free health coverage to eligible Orange County residents with limited income. Covered California is the state's health insurance marketplace where Orange County residents may shop for health plans and access financial assistance if they qualify for it.

According to Covered California:

- As of December 2021, Orange County has a total of 155,660 residents enrolled in Covered California:
    - 138,470 enrollees are subsidized
    - 17,200 enrollees are unsubsidized

- Covered California Enrollment in Orange County by FPL December 2021

138% FPL or less	2.5%
138% FPL to 150% FPL	22.2%
150% FPL to 200% FPL	23.4%
200% FPL to 250% FPL	13.3%
250% FPL to 400% FPL	25.7%
400% FPL to 600% FPL	5.4%
600% FPL or greater	2.3%

- Enrollment in Orange County by Health Plan, December 2021

Anthem Blue Cross of California	14,310
Blue Shield of California	42,770
Health Net	28,650
Kaiser Permanente	31,650
Molina Healthcare	1,190
Oscar Health Plan of California	37,080

Agenda Item

AGENDA STAFF REPORT

ASR Control 22-000427

MEETING DATE:	05/10/22
LEGAL ENTITY TAKING ACTION:	Board of Supervisors
BOARD OF SUPERVISORS DISTRICT(S):	All Districts
SUBMITTING AGENCY/DEPARTMENT:	Health Care Agency (Approved)
DEPARTMENT CONTACT PERSON(S):	Torhon Barnes (714) 834-5109 Clayton Chau (714) 834-2830

SUBJECT: Amendments to CalOptima Ordinance

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	Approved Ordinance to Form	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** N/A

Staffing Impact: No **# of Positions:** **Sole Source:** N/A

Current Fiscal Year Revenue: N/A

Funding Source: N/A **County Audit in last 3 years:** No

Prior Board Action: 10/18/2011 #29, 10/04/2011 #38

RECOMMENDED ACTION(S):

1. Read title of Ordinance, "An Ordinance of the County of Orange, California amending sections 4-11-2, of the Codified Ordinances of the County of Orange Regarding the Orange County Health Authority."
2. Order further reading of Ordinance be waived.
3. Consider the matter.
4. Direct Ordinance be placed on the agenda for the next regularly scheduled Board of Supervisors meeting for adoption.
5. Consider the matter and adopt the Ordinance at the next regularly scheduled meeting.

SUMMARY:

Modifying the CalOptima Ordinance will allow the CalOptima to participate in the California Health Benefit Exchange.

BACKGROUND INFORMATION:

The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010. The ACA allowed states to set up their own state-based marketplace or exchange to provide its residents with an avenue to purchase their health insurance and receive discounts in the form of federal subsidies if eligible.

California was the first state to introduce legislation to create the California Health Benefit Exchange, known as Covered California. In September of 2010, then-Governor Arnold Schwarzenegger signed Assembly Bill 1602, the California Patient Protection and Affordable Care Act and Senate Bill 900 into law.

On October 4, 2011, the Orange County Board of Supervisors amended the CalOptima ordinance that stated, "It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market."

On May 5, 2022, the CalOptima Board of Directors will consider authorizing the CalOptima Chief Executive Officer to seek an amendment of the CalOptima Ordinance from the Board of Supervisors regarding allowing CalOptima to participate in Covered California.

CalOptima's participation in Covered California would substantially benefit the County and CalOptima members for the following four core reasons:

- Reduce churn by providing CalOptima members continuity of care for former Medi-Cal members.
- Improve access by expanding the options to ensure more individuals are covered.
- Extend local expertise that amplifies the impact of CalOptima's community focus.
- Bolster the safety net by bringing revenue that can be invested back into community health.

The proposed amendments authorize CalOptima to participate in the Covered California as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations, and aligns the current Ordinance with Welfare & Institutions Code Section 14087.54.

In the event the Board adopts the amendments, CalOptima plans to begin building internal capabilities for a plan launch in January 2024.

FINANCIAL IMPACT:

N/A

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - Proposed Amendments to Orange County Codified Ordinance, Section 4-11-2
Attachment B - Current Version of Orange County Codified Ordinance, Section 4-11-2-2
Attachment C - Welfare & Institutions Code Section 14087.54

ORDINANCE NO. 22-___

AN ORDINANCE OF THE COUNTY OF ORANGE, CALIFORNIA AMENDING SECTIONS 4-11-2 OF THE CODIFIED ORDINANCES OF THE COUNTY OF ORANGE REGARDING THE ORANGE COUNTY HEALTH AUTHORITY

The Board of Supervisors of the County of Orange, California ordains as follows:

SECTION 1. Section 4-11-12 of Article 1 of Division 11 of Title 4 of the Codified Ordinances of the County of Orange is hereby amended to read as follows:

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts specified in Welfare and Institutions Code section 14087.5 with the California Department of Health Care Services and to arrange for the provision of health care services ~~to qualifying individuals who lack sufficient annual income to meet the cost of healthcare, and whose other assets are so limited that their application toward the cost of health care would jeopardize the person's or family's future minimum self-maintenance and security, pursuant to~~ provided pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions C~~c~~ode~~, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market.~~

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for the following persons ~~who are eligible to receive medical benefits~~:

(1) Persons who are eligible to receive medical benefits ~~U~~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.).~~;~~

(2) Persons who are eligible to receive medical benefits ~~U~~under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).~~; and~~

(3) ~~As otherwise permitted by Welfare and Institutions Code section 14087.54~~Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The Health Authority shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(g) The Health Authority shall have the power to enter into contracts for ~~to~~ provisionde ofa health care services~~delivery system for the~~ to individuals in the service area who are eligible to receive medical benefit under any publicly supported program, such as ~~of~~ Medi-Cal ~~eligible,~~ and Healthy Families, if the Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose~~eligible or other low income or indigent people in the County of Orange~~.

(h) The Health Authority shall ~~not~~ have the power to ~~offer a health insurance product in competition with private managed care organizations or private insurance plans in~~ participate in the ~~any~~ California Health ~~Insurance~~ Benefit Exchange (commonly known as Covered California) as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations~~created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining healthcare~~. The Health Authority shall have the power to participate in any other publicly supported health care program that the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health ~~Insurance~~ Benefit Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

(Ord. No. 3896, § 1, 8-10-93; Ord. No. 98-10, § 1, 7-21-98; Ord. No. 00-8, § 1, 8-1-00; Ord. No. 05-008, § 1, 5-24-05; Ord. No. 06-012, § 1, 12-5-06; Ord. No. 09-001, 1-13-09; Ord. No. 11-013, 5-3-11)

ORANGE COUNTY, CALIFORNIA, CODE OF ORDINANCES
TITLE 4 - HEALTH SANITATION AND ANIMAL REGULATIONS
Division 11 ORANGE COUNTY HEALTH AUTHORITY

ARTICLE 1. GENERAL PROVISIONS

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts with the California Department of Health Care Services and to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare, and whose other assets are so limited that their application toward the cost of health care would jeopardize the person's or family's future minimum self-maintenance and security, pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions code, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market.

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for persons who are eligible to receive medical benefits:

(1) 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.);

(2) Under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) As otherwise permitted by Welfare and Institutions Code section 14087.54.

(g) The Health Authority shall have the power to contract to provide a health care delivery system for the benefit of Medi-Cal eligible, Healthy Families eligible or other low income or indigent people in the County of Orange.

(h) The Health Authority shall not have the power to offer a health insurance product in competition with private managed care organizations or private insurance plans in any Health Insurance Exchange created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve

Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health Insurance Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

(Ord. No. 3896, § 1, 8-10-93; Ord. No. 98-10, § 1, 7-21-98; Ord. No. 00-8, § 1, 8-1-00; Ord. No. 05-008, § 1, 5-24-05; Ord. No. 06-012, § 1, 12-5-06; Ord. No. 09-001, 1-13-09; Ord. No. 11-013, 5-3-11)

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(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for persons who are eligible to receive medical benefits:

(1) 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.);

(2) Under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) As otherwise permitted by Welfare and Institutions Code section 14087.54.

(g) The Health Authority shall have the power to contract to provide a health care delivery system for the benefit of Medi-Cal eligible, Healthy Families eligible or other low income or indigent people in the County of Orange.

(h) The Health Authority shall not have the power to offer a health insurance product in competition with private managed care organizations or private insurance plans in any Health Insurance Exchange created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve

Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health Insurance Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

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WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.67] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 2.8. County Health Systems [14087.5 - 14087.95] *(Heading of Article 2.8 amended by Stats. 1988, Ch. 1348, Sec. 1.)*

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 June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

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

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

- PACE

On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountability and Results Tracking
- Future Growth

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

Mission

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

Vision

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

Core Strategy

The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.

Strategic Priorities 2022-2025 / Tactical Priorities 2022-2025

Organizational and Leadership Development

- Cultural Alignment throughout CalOptima
- Talent Development & Succession Planning
- Effective & Efficient Organizational Structures
- Aligned Operating Systems & Structures
- Staff Leadership Development Institutes (Training) & Executive Coaching
- Organizational Excellence Annual Priorities
- On-going updated Policies & Procedures
- Governance & Regulatory Compliance Trainings
- Board Priorities

Overcoming Health Disparities

- CalOptima's 'Voice & Influence'
- Local, Federal & State Advocacy
- Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations
- Support for Community Clinics & Safety Net Providers
- Medical Affairs Value Based Care Delivery
- CalAIM initiatives
- Focus on Equity & Communities Impacted by Health Inequities
- Co-Created Needs Assessment within Equity Communities & Neighborhoods
- ITS Architecture that supports the Core Strategy
- DHCS Comprehensive Quality Strategy

Finance and Resource Allocation

Operating Budget Priorities

- Balanced Operating Budget
- New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy)
- Fiscal Strategic Plan Priorities (KPI/KFI)
- Quarterly Budget Reconciliation

Capital Budget Priorities

- Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s)
- New ITS Architecture

New Policy and Program Development based on Funding

- Reserve/Spending Policies & Priorities
- Aligned Incentives for Network Quality & Compliance
- Contracting & Vendor/Provider Management

Accountabilities & Results Tracking

- Updated By-Laws
- Executive Priorities & Outcomes
- COBAR Clarity
- Inter-Agency Team Priorities
- Public/Private Implementation Work Group
- Resource Allocation for Inter-Agency Initiatives
- Partner CalAIM Opportunities for Outcomes Metrics
- Research Analytics for Efficacy Reporting (Metrics of Success)
- Regular Board Training Sessions

Future Growth

- Member Access to Quality Care
- Participate in Covered California
- Site Utilization (PACE etc.)
- Services/Programs Aligned with Future Reimbursements from DHCS and CMS
- Demographic & Analytics by Micro-Community
- ITS Data Sharing to benefit the member
- Implement Programs & Services (CalAIM) & Plan for Site Locations
- Industry Trends Analysis (Trade Associations, Lobbyists etc.)
- Enhanced ITS security posture

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

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

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

/s/ [signature]
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/ [signature]
Sharon Dwiers, Clerk of the Board

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Report Item
19. Approve Actions Related to the Community Enrollers for Medi-Cal Notice of Funding Opportunity

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Deanne Thompson, Executive Director, Marketing and Communications, (657) 550-4736

Recommended Actions
1. Approve CalOptima Health staff's recommendations to administer grant agreements and award payments totaling $1,993,486 to selected grant recipients (listed in Attachment 1) for the Community Enroller grant awards.

Background
On January 1, 2024, a new law in California went into effect that provides eligible adults 26-49 years of age with access to full-scope Medi-Cal services, regardless of immigration status. All other eligibility rules, including income limits, still apply. This Medi-Cal initiative, called the Age 26 through 49 Adult Full Scope Medi-Cal Expansion (Adult Expansion), is modeled after the Young Adult Expansion and the Older Adult Expansion and extends full-scope Medi-Cal to all other age ranges, regardless of immigration status.

CalOptima Health estimates that the County of Orange Social Services Agency (SSA) may enroll 40,000 to 70,000 individuals into Adult Expansion in the first year. These new enrollees will become CalOptima Health members.

A Board of Directors (Board) amended action on December 7, 2023 (Consent Calendar Item #21, Rev. 12/7/23), authorized unbudgeted expenditures and appropriated up to $5,000,000 from existing reserves to implement the Adult Expansion Outreach Strategy.

The following table provides an updated breakdown of the activity and estimated costs. These are estimated costs only and final costs will be dependent on final vendor negotiations, event locations, and additional marketing costs. Staff will procure vendor contracts in accordance with CalOptima Health Policy GA.5002: Purchasing Policy and will return to the Board if additional funding is needed.

Activities	Original Estimated Cost (as presented in 12/7/23)	Updated Estimated Cost
Printed Materials • Flyers/posters	Up to $150,000	Up to $150,000
Community Enrollers	Up to $750,000	$2,000,000

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Activities	**Original Estimated Cost (as presented in 12/7/23)**	**Updated Estimated Cost**
• Countywide enrollment support services, offered in all threshold languages		
Community Events • Rentals, supplies, equipment and logistics	Up to $150,000	Up to $500,000
Marketing • Development of advertising and marketing materials in all threshold languages	Up to $450,000	Up to $508,000
Advertising • Radio, digital, broadcast, print and other media in all threshold languages	Up to $1,000,000	Up to $1,342,000
CalOptima Health Mobile Unit		Up to $500,000
Total of Adult Expansion Outreach Strategy Reserve Funds	**$2,500,000**	**$5,000,000**

Discussion

Similar to CalOptima Health's efforts to bring awareness to the community and its members about Medi-Cal renewal and CalFresh enrollment, CalOptima Health will partner with the County of Orange Social Services Agency on Adult Expansion. In December 2023 the Board approved actions to execute agreements with partner organizations to conduct community enrollment in the Medi-Cal and CalFresh programs. CalOptima Health staff released a notice of funding opportunity (NOFO) to solicit applications from qualified community-based partners to conduct the necessary community enrollment work. Each organization could apply for between $200,000 and $500,000 to conduct enrollment support for the Medi-Cal and CalFresh programs.

The Community Enrollers for Medi-Cal NOFO were released to the public on May 6, 2024, via distribution lists and on the CalOptima Health website. CalOptima Health staff conducted a community forum for all interested community organizations describing the grant application process, funding priority areas, applicant eligibility criteria, and responded to questions ahead of the open-portal application period, which ran from May 6, 2024, to June 14, 2024. In total, CalOptima Health received and reviewed 26 completed proposals from 26 organizations. An internal committee of evaluators from CalOptima Health reviewed and scored the submitted proposals based on the review criteria in Attachment 2.

Evaluators scored all applications on these criteria using a scoring rubric, and their scores were averaged to give each application a final score. These scores were ranked, and the top scorers are being recommended for grant funding. Recommendations include funding 7 of the 26 proposals for a total of $1,993,486. In their proposals, the recommended organizations demonstrated the ability (i) to identify,

reach, and serve hard-to-reach communities, including undocumented individuals; and (ii) comprehensive strategies to serve individuals currently participating in their programs/services and in the community, including phone banking, door-to-door canvassing, community events, social media and other activities. These recommended organizations will also provide services in all seven threshold languages and will cover all service areas in Orange County.

With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 2. Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact
The recommended action has no additional fiscal impact. A previous Board action on December 7, 2023, authorized funding in an amount not to exceed $5.0 million from existing reserves to implement the Adult Expansion Outreach Strategy, including the recommended community grants.

Rationale for Recommendation
Funding these community grants will aid CalOptima Health in efforts to conduct robust regional outreach and education campaigns, provide and promote countywide enrollment activities, and increase access to care for adult residents, regardless of immigration status, in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Notice of Funding Opportunity Review Criteria
3. Applicant Scores
4. Award Recommendations and Amounts

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 7, 2023	Authorize Adult Expansion Outreach Strategy to Make Eligible Adults Ages 26 Through 49 Aware of the Opportunity to Apply for Full-Scope Medi-Cal Regardless of Immigration Status	-	$5,000,000

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

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Attachment to the August 1, 2024 Board of Directors Meeting – Agenda Item 19

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Abrazar, Inc.	7101 Wyoming Street	Westminster	US-CA	92683
Camino Health Center	31351 Rancho Viejo Rd Suite# 201	San Juan Capistrano	US-CA	92675
Community Action Partnership of Orange County	11870 Monarch St	Garden Grove	US-CA	91841
Give For A Smile	10861 Acacia Parkway	Garden Grove	US-CA	92840
Orange County United Way	18012 Mitchell South	Irvine	US-CA	92614
Serve the People Community Health Center	1206 E. 17th Street, Suite 101	Santa Ana	US-CA	92604
Vista Community Clinic	201 S. Harbor Blvd.	La Habra	US-CA	90631

ATTACHMENT 2. PROPOSAL RATING CRITERIA:

	Criterion	Maximum Points Per Criterion	Criterion Description and Scoring Logic
1	**Outreach Scope**	15	Applicant demonstrates the ability to reach variety of areas in OC, including one or more SPAs. Applicant demonstrates the ability reach diverse communities of individuals and families in Orange County. Applicant demonstrates ability to provide services in one or more threshold languages. Applicant demonstrates the ability to serve multiple age groups and families.
2	**Program Description**	10	Applicant's program description is clear and concise. Applicant's program description provides clear rationale for the strategies the applicant intends to implement and connection to how those activities will produce the proposed outcomes.
3	**Program Implementation**	10 (**5 points** if each 1 FTE enroller will perform minimum service requirements. **3 points** allotted if plan clearly articulates how program will be implemented. **2 points** allotted for strategic and feasible staffing model)	Applicant proposes objectives that meet or exceed minimum service requirements; implementation plan clearly demonstrates how activities will result in accomplishing proposed metrics; staffing proposed will be able to accomplish said objectives Applicant's proposed Implementation Plan is complete and includes specific objectives, logical and feasible activities, staffing expectations, and clearly defined measures of success.

4	**Regional Knowledge and Community Experience**	15	Applicant compellingly describes how the voice of lived experience will be incorporated into program design and implementation. Application details critical regional partnerships or collaborative partners to accomplish program deliverables. Application clearly states history of service delivery and/or community connections in Orange County. Application clearly states the applicant's intent and ability to serve Orange County residents. Applicant cites successful previous history managing grants and/or contracts with CalOptima Health.
5	**Organizational Readiness**	10	Proposal and Implementation Plan detail feasible timeline to accomplish project deliverables. Proposal demonstrates minimal start-up time required to implement programming.
6	**Skills & Experience**	10	Applicant effectively details experience or history conducting enrollment activities. Applicant demonstrates experience serving populations without documentation.
7	**Applicant Capacity**	10	Applicant sufficiently demonstrates a current roster and number of enrollers on staff OR provides an effective proposal to quickly onboard sufficient workforce to accomplish deliverables. Applicant demonstrates healthy fiscal organizational position including larger total budgets, robust Board of Directors, and diverse funding streams. If the applicant manages other or multiple CalOptima Health grants, the applicant demonstrates how they will effectively/strategically utilize multiple streams of funds. Applicant effectively demonstrates financial and management capacity to carry out the project, as evidenced by the submission of required materials in application portal.
8	**Evaluation Plan**	10	Applicant clearly articulates how they will track, record, and report-out on metrics including deliverables, outputs, outcomes, and budget spend. Application describes previous experience constructing internal systems or plans to evaluate effective program performance.

9	**Budget Efficiency**	10	Applicant proposes program budget that feasibly and reasonably aligns with proposal activities, staffing, and outcomes. The applicant demonstrates connection to an appropriate and credentialed supervising provider. The application packet includes a letter of commitment or attestation of plan for support services.

Attachment to the August 1, 2024 Board of Directors Meeting – Agenda Item 19

SCORES OF COMMUNITY ENROLLERS NOFO APPLICANTS

	Community Enrollers NOFO Applicants	**Score out of 100**	**Funding Recommendation**
1	Community Action Partnership of Orange County	91.8	Fund
2	Abrazar, Inc.	90.2	Fund
3	Orange County United Way	89.6	Fund
4	Give For A Smile	87.7	Fund
5	Vista Community Clinic	85.4	Fund
6	Serve the People Community Health Center	85.2	Fund
7	Camino Health Center	85.0	Fund
8	AltaMed Health Services Corporation	84.8	Do Not Fund
9	Community Health Initiative of Orange County	84.5	Do Not Fund
10	Latino Center for Prevention and Action in Health and Welfare dba Latino Health Access	83.6	Do Not Fund
11	Orange County Association for Mental Health dba Mental Health Association of Orange County	83.5	Do Not Fund
12	Southland Integrated Services Inc.	83.3	Do Not Fund
13	Friends of Family Health Center	82.2	Do Not Fund
14	Coalition of Orange County Community Health Centers	80.2	Do Not Fund
15	Vision y Compromiso	77.9	Do Not Fund
16	Family Assistance Ministries	71.4	Do Not Fund
17	Homeless Intervention Services of Orange County	65.0	Do Not Fund
18	Covenant House California	64.2	Do Not Fund
19	St. Louise Resource Services	63.8	Do Not Fund
20	Poppy Life Care	49.9	Do Not Fund
21	Krista Care LLC	48.0	Do Not Fund
22	Urban Social Services and Advocacy	47.4	Do Not Fund
23	Hawkins Hawkins Tax Services	46.0	Do Not Fund
24	Project-Respectt, Inc	44.9	Do Not Fund
25	Naturally Fit Movement	33.4	Do Not Fund
26	New Beginnings Reintegration and Continuum Care Services, Inc.	27.8	Do Not Fund

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ORGANIZATIONS SELECTED FOR AWARD AND RECOMMENDED AMOUNTS

Name	Grant Amount
Abrazar, Inc.	$200,000
Camino Health Center	$250,000
Community Action Partnership of Orange County	$365,000
Give For A Smile	$233,628
Orange County United Way	$354,408
Serve the People Community Health Center	$383,020
Vista Community Clinic	$207,430
Total	$1,993,486

CalOptima Health Board Action Agenda Referral

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

Report Item

20. Approve Actions Related to the Incentive Payment Program for Justice-Involved Services Learning Collaborative

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize CalOptima Health staff to develop and release a notice of funding opportunity related to the Justice-Involved Services Learning Collaborative program.
2. Authorize up to $1 million from CalAIM Incentive Payment Program, Program Year 1, to support up to five entities in an amount of up to $200,000 per entity for Enhanced Care Management provider capacity building.

Background

In preparation for the start of CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) provided managed care plans with performance incentives through the CalAIM Incentive Payment Program (IPP) to promote provider participation and capacity building. CalOptima Health was awarded $44,954,059 for Program Year (PY) 1 (2022) paid in two equal installments in May 2022 and July 2023. In December 2023, CalOptima Health received $17.2 million out of the available $22.2 million for the first installment of PY 2 (2023).

As of May 2024, there is approximately $5.2 million in IPP PY 1 funding remaining for new initiatives. As CalOptima Health continues to implement CalAIM benefits and monitor progress with IPP measurement submissions, staff has identified areas for improvement. One such area is the roll-out of the Justice-Involved (JI) in-reach services. These services involve CalOptima Health contracted ECM providers entering Orange County's Correctional Facilities to coordinate a community re-entry care plan that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release. These services require intensive coordination and collaboration between CalOptima Health, its contracted ECM providers, and multiple Orange County agencies, including, but not limited to, Orange County Sherriff Department (OCSD), the Health Care Agency (HCA), and the Social Services Agency (SSA). These services, which will be available for up to 90 days prior to release, are new to the State and will launch in Orange County no sooner than January 2025.

Discussion

To successfully implement JI pre-release in-reach services, CalOptima Health staff is proposing to launch a JI Services Notice of Funding Opportunity (NOFO) for a JI Services Learning Collaborative (Learning Collaborative). Through the Learning Collaborative, the selected organizations will meet with CalOptima Health staff regularly to streamline implementation, share lessons learned, and develop a JI Best Practices Guide. Thus far, ECM services have only been offered to the JI population of focus post-

release. In order to successfully shift service delivery to inside the walls of correctional facilities, attention to detail will be necessary, as will identifying barriers and developing collaborative solutions. The Learning Collaborative will ensure that CalOptima Health and its partners can pave the way for additional providers to join in serving this vulnerable population, ensuring those leaving the carceral system receive the comprehensive care and support they deserve.

CalOptima Health staff seek authority to offer this funding opportunity to currently contracted ECM providers who have elected to support the JI population of focus and select up to five applicants for grant awards. The NOFO will provide up to $200,000 in capacity building funds through a grant agreement.

Staff will develop and release the NOFO in accordance with CalOptima Health Policy AA.1400: Grant Management. Staff will return to the Board to request review and approval of recommended grantees in November 2024.

Fiscal Impact

The recommended action will be funded by the DHCS CalAIM IPP PY 1 unallocated balance and has no additional net fiscal impact.

Rationale for Recommendation

To ensure the success of in-reach services for CalOptima Heath's JI members, launching this Learning Collaborative is essential as it will facilitate the much-needed coordination among all stakeholders, allowing CalOptima Health to address and overcome existing barriers effectively and develop an experience-based set of best practices.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. NOFO "JI Services Learning Collaborative"

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.	-	$45,000,000 (in aggregate)

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.	-	$45,000,000 (in aggregate)
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for AltaMed Health Services Corporation		$45,000,000 (in aggregate)

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Notice of Funding Opportunity: Justice-Involved Services Learning Collaborative

Application Deadline — September 13, 2024 (5:00 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. With a strategic goal of decreasing health inequities, CalOptima Health is engaging in programs and expanding partnerships to better serve members who are at greater risk for poor health outcomes.

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear plan to transform California's Medi-Cal program and to seamlessly integrate medical and social services. Led by California's Department of Health Care Services (DHCS), the goal of CalAIM is to improve outcomes for Medi-Cal members, especially those with the most complex needs.

Research has demonstrated that justice-involved individuals, defined for these purposes as people who are now, or have spent time, in jails, youth correctional facilities, or prisons, are at higher risk for injury and death than the general public. As a part of CalAIM, to address these documented poor health outcomes, DHCS has established pre-release Medi-Cal enrollment strategies to ensure individuals have continuity of coverage upon their release, as well as access to key services to help them successfully return to their communities. California was the first state in the nation approved to offer a targeted set of "in-reach" services to youth and eligible adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release.

It is anticipated that on January 1, 2025, adult and youth detention facilities in Orange County will go-live with pre-release services, including "in-reach" services in the adult detention facilities. To support those service providers, understand best practices, share lessons learned, and streamline implementation, CalOptima Health is hosting and funding a Justice-Involved Services Learning Collaborative.

Description of Funding Opportunity

All applications must demonstrate the organization's capacity for and commitment to providing in-reach services in Orange County's adult detention facilities.

This funding opportunity will provide grant dollars to support an organization's launch of in-reach justice-involved services within adult detention facilities and participation in the learning collaborative. Up to $200,000 per organization will be available to support internal capacity building in preparation for in-reach services and to support staff time committed to participation in the learning collaborative, including sharing of lessons learned, discussion and fine-tuning of best practice concepts, and contribute to a public facing document that communicates outcomes from the collaborative.

Requirements for Proposed Grant Applications

1. Applicant must commit a minimum of two staff members to consistently participate in all learning collaborative meetings, which will be held twice per month. It is preferred that those staff members include someone with oversight of the direct services (e.g. lead care manager) and someone at the executive leadership level.
2. Applicants must be actively involved in the collaborative, including sharing lessons learned, discussing and fine-tuning best practice concepts, and contributing to a public facing document that communicates outcomes from the collaborative.
3. Applicants must commit to launching justice involved in-reach in Orange County's adult detention facilities services by December 1, 2024.
4. Applicants must meet the following in-reach service thresholds throughout the project:
   - 60 individuals served by May 31, 2025
   - 90 individuals served by August 31, 2025
   - 120 serviced by November 30, 2025
5. Applicants must attempt to ensure continuity of care for all individuals engaged in in-reach services by submitting a referral for ECM, obtaining authorizations, and providing ECM services for all individuals upon release.
6. Applicants must submit quarterly reports on their experiences.

Grant Budgets, Amounts, Duration and Allowable Expenses

Through this opportunity up to five selected applicants will be awarded up to $200,000 for a 12-month project. Organizations must indicate how they will utilize the funding, whether to cover staff time or conduct organizational capacity building such as technology upgrades, purchase of new equipment, creation of a pre-paid phone line to enhance communication with individuals still residing in detention or correctional facilities or onboarding new positions.

Allowable Expenses

Examples of allowable expenses for funds include hiring and onboarding staff, the continued training and development of direct program and/or supervised organization staff, the purchase of technology software and hardware necessary to provide services, updating or implementation of billing and claims systems, the creation and distribution of educational outreach materials and hosting community-based events.

Note: Funds may not be used for staff time that is dedicated to provision of DHCS or CalOptima Health billable service or for partisan lobbying efforts.

Entities Eligible to Apply

1. Applicants must already be contracted with CalOptima Health for the provision of Enhanced Care Management (ECM) services and have already elected to support the adult justice-involved population of focus –OR– the applicant must be accepted into the September 2024 ECM Academy and be preparing to contact for ECM services.
2. Applicants must demonstrate the capacity to serve minimally 120 justice-involved individuals at any given time with ECM services. It is anticipated that these services will be staffed according to the ECM policy guide.
3. Applicants must have operations in Orange County and currently serve CalOptima Health members through their programs and services.
4. Applicants may submit only one application.
5. Applicants that previously received funding from CalOptima Health must be/have been in good standing with the terms of that grant agreement to be eligible for new funding.
6. **Remember:** Carefully review all threshold eligibility requirements. Applicants who fail to meet threshold requirements will be deemed ineligible. Applicants must successfully complete an application and submit it by the deadline to be considered for funding.

Community Investment Strategy

CalOptima Health is prioritizing projects and programs that are trauma-informed, inclusive, non-residency restricted, low barrier, and aligned with housing-first and harm-reduction principles. This includes ensuring the "voice of lived experience" is integrated into all phases: design, development, implementation and evaluation.

Proposal Evaluation Criteria

	Criterion	Maximum Points	Description of basis for assigning points
	Evaluation Component	**Point Available**	**Description**
1	Outreach Scope	15	Applicant ability to reach a number of jails, correctional institutions, etc; ability to reach a variety of areas in OC; variety of threshold languages available.
2	Program Description	10	Program description is clear and concise; clear rationale for the strategies they are employing and connection to how those activities will produce the outcomes they propose.
3	Program Implementation	15	Objectives that meet or exceed minimum service requirement; implementation plan clearly demonstrates how activities will result in accomplishing proposed

			metrics; staffing proposed will be able to accomplish said objectives.
4	Regional Knowledge and Community Experience	15	How will they incorporate voice of lived experience, do they mention critical partnerships, are they based in Orange County or have strong connections to the region.
5	Organizational Readiness	10	Timeline is feasible and start-up time needed is minimal.
7	Skills and Experience	15	Past experience conducting working with this population.
6	Applicant Capacity	10	Number of dedicated staff; strength of organizational financial position, strong board of directors, diversity of funding sources so not heavily reliant on this grant; consider status of other grants from CalOptima Health.
7	Evaluation Plan	10	Do they have built-in systems and experience doing this kind of evaluation and reflection.
	Total Earnable Points	**100**	

Timeline

Activity	Date
NOFO Released and Portal Opens	8/12/2024 at 9 a.m.
Bidder's Conference *(Virtual)*	8/26/2024 at 1 p.m.
Questions Posted from Bidder's Conference	8/30/2024
Application Deadline	**9/13/2024 at 5 p.m.**
Internal Review	Sept 2024
CalOptima Health Board of Directors Meeting	**11/7/2024**
Announcement of Approved Grants	11/7/2024
Grant Agreements Processed	November 2024
Grant Start Dates	12/1/2024

Documents and Portal Access

All documents related to this NOFO, and application portal access will be made available at this site: https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/FundingOpportunities

Portal can be directly accessed from this link: <<insert link>>

Bidder's Conferences

Join our Bidder's Conferences for this funding opportunity by registering in advance through the link below:

Bidder's Conference
Date and Time: Monday, August 26th, 2024, at 1 p.m. PST
Link: https://us06web.zoom.us/webinar/register/WN_V2vvJZ9_R7O87sH6QwquQA

Questions?

Please forward any questions about the grant opportunity or application process to the CalAIM inbox at CalAIM@caloptima.org.