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

**THURSDAY, MAY 6, 2021**
**2:00 P.M.**

**505 CITY PARKWAY WEST, SUITES 108-109**
**ORANGE, CALIFORNIA 92868**


BOARD OF DIRECTORS

Supervisor Andrew Do, Chair
Isabel Becerra, Vice Chair
Supervisor Doug Chaffee
Clayton Chau, M.D.
Clayton Corwin
Mary Giammona, M.D.
Victor Jordan
J. Scott Schoeffel
Nancy Shivers, R.N.
Trieu Tran, M.D.
Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER
Richard Sanchez

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
Sharon Dwiers


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

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

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

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

1) **Listen to the live audio at +1 (631) 992-3221 Access Code: 415-059-181 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/7562194000330665744 **rather than attending in person. Webinar instructions are provided below.**

**CALL TO ORDER**
Pledge of Allegiance
Establish Quorum

**PRESENTATIONS/INTRODUCTIONS**
None.

**MANAGEMENT REPORTS**

1. Chief Executive Officer Report
   a. Executive Director, Quality & Population Health Management Appointment
   b. 2021 Report to the Community
   c. California Advancing and Innovating Medi-Cal (CalAIM) Stakeholder Meeting
   d. Homeless Health Stakeholder Engagement
   e. COVID-19 Response
   f. Letters of Support
   g. All Hands Guest Speaker
   h. CEO Community Presentations

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

3. Introduction to the FY 2021-22 CalOptima Budget: Part 2

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

**CONSENT CALENDAR**

4. Minutes
   a. Approve Minutes of the April 1, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of February 11, 2021 CalOptima Board of Directors' Provider Advisory Committee and the Minutes of the February 11, 2021 CalOptima Board of Directors' Member Advisory Committee

5. Consider Approval of Modifications to CalOptima Medical Affairs Policies and Procedures

6. Consider Extension of Ancillary Services Contracts

7. Consider Extension of the Professional Services Contracts for Clinics, Except Those Affiliated with Providence St. Joseph Healthcare

8. Consider Extension of the Professional Services Contracts for Clinics Associated with Providence St. Joseph Healthcare

9. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts Affiliated with Providence St. Joseph Heritage Healthcare and its Affiliates

10. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts, Except Those Associated with Providence St. Joseph Heritage Healthcare and its Affiliates

11. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Employee Handbook and Human Resources Policy; Consider Authorizing Unbudgeted Sick Leave Expenditures

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

**REPORTS/DISCUSSION ITEMS**

**ADMINISTRATIVE**

13. Consider Adopting Resolutions Authorizing the Appointment of Retired Annuitants to Carry out the Duties and Responsibilities of Medical Directors During the Recruitment to Permanently Fill Vacancies and Ensure Continuity of Services and Prevent the Stoppage of Public Business

**NETWORK OPERATIONS**

14. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

15. Consider Approval of CalOptima Policy to Establish a Process and Criteria for Health Network Contract Model Changes

**PUBLIC AFFAIRS**

16. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

17. Consider Selecting and Contracting with a Vendor for Federal Advocacy Services

**TO FOLLOW CLOSED SESSION**

18. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare and OneCare Connect Bid for Calendar Year 2022 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare and OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement

**ADVISORY COMMITTEE UPDATES**

19. Member Advisory Committee Update

20. Provider Advisory Committee Update

**BOARD MEMBER COMMENTS**

**CLOSED SESSION**

CS 1 Pursuant to Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION: Stanford Health Care v. CalOptima et al. SCSC Case No. 21CV375310

CS 2 Pursuant to Government Code section 54956.9, subdivision (d)(2) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION: (One Case)

CS 3 Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare and OneCare Connect

CS 4 Pursuant to Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth and Mai Hu, Newmark Knight Frank
Negotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment

**ADJOURNMENT**

## How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on May 6, 2021 2:00 PM PDT at: https://attendee.gotowebinar.com/register/7562194000330665744

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

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: (631)992-3221

   Access Code: 415-059-181

   Audio PIN: Shown after joining the webinar

# MEMORANDUM

| | |
|---|---|
| DATE: | April 29, 2021 |
| TO: | CalOptima Board of Directors |
| FROM: | Richard Sanchez, Chief Executive Officer |
| SUBJECT: | CEO Report — May 6, 2021, Board of Directors Meeting |
| COPY: | Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee |

**Marie Jeannis Named Executive Director, Quality & Population Health Management**
After serving in an interim role, Marie Jeannis has been appointed the permanent Executive Director, Quality & Population Health Management. Marie began her career with CalOptima in 2002 in Case Management, later becoming director for seven years. In 2014, she joined the Enterprise Analytics team. As the most recent director of Enterprise Analytics, she is recognized for her role in creating multiple dashboards and reports to support the success of key initiatives, such as the Homeless Health Initiative, Whole Child Model and Health Homes Program. As Executive Director, Marie will to be responsible for the management and oversight of CalOptima's Quality and Population Health Management teams. Marie is a master's-prepared Registered Nurse with a specialization in health informatics and a certified case manager.

**CalOptima Releases 2021 Report to the Community Focused on Pandemic Response**
In a creative approach to reaching stakeholders who are not receiving mail at their offices, CalOptima's Communications team developed an electronic Report to the Community that captures accomplishments during the pandemic year. Using a Chrome browser, please view the report here. On April 15, CalOptima distributed the report via an email blast to more than 2,700 provider and community partners, and to all employees. The report is also posted on the website and social media. Special thanks to your Board for the steady guidance that enabled CalOptima to uphold our mission through unprecedented challenges.

**California Advancing and Innovating Medi-Cal (CalAIM) Stakeholder Meeting Set**
In preparation to launch CalAIM in January 2022, CalOptima is hosting a community stakeholder meeting on Friday, May 14, 10:30–11:30 a.m. CalOptima plans to provide an overview of CalAIM, discuss the target populations and outreach, and conduct a Q&A session. Invitations were distributed broadly to providers, community-based organizations, elected officials and others. Registration is available here.

**CalOptima Planning for Homeless Health Stakeholder Engagement, Research**
In 2019, as part of our Homeless Health Initiatives, CalOptima solicited input from stakeholders about best practices to engage individuals whose health outcomes are impacted by their experience with homelessness. The stakeholders recommended that CalOptima hear directly from members with "lived experience" with homelessness. While CalOptima initially planned in-person town halls and interviews, the extended impacts of COVID-19 caused us to revise our strategy to incorporate virtual member focus groups and key informant interviews. We also

added a provider research component to include a broader view in program design and strategy development. Currently, CalOptima proposes to engage a third-party consultant to conduct research, which will provide confidentiality for participating members. We plan to release a Request for Proposal in May to identify a qualified research vendor that can conduct all research activities and develop an engagement framework by December 2021. We will bring a vendor contract to your Board for consideration later this year.

**COVID-19 Response Adjusts to Expanded Vaccine Eligibility**
On April 15, Orange County began permitting COVID-19 vaccination of residents 16 years or older. The expanded eligibility means that CalOptima now has approximately 569,000 members who can be vaccinated under the new criteria.

- *Vaccination Data*: Your Board requested ongoing data regarding members who have been vaccinated. While recent California Immunization Registry (CAIR) data shows an increase in vaccinations from the prior month, CAIR information is not real time. Therefore, many more members are likely to have received the vaccine than this figure indicates. As of April 16, 71,274 CalOptima members have been vaccinated, and of those, 64,491 are eligible for Member Health Rewards.
- *Text Messaging Campaign*: On April 28, CalOptima released a third round of text messages to more than 240,000 cell phones. The text carries a notice about the expanded eligibility and a reminder about the Member Health Rewards.
- *Trusted Messenger Videos:* On April 14, CalOptima distributed a press release announcing our video series featuring community leaders sharing messages about COVID-19 vaccine safety in English, Spanish and Vietnamese. The 15- and 30-second videos have been posted on Facebook, Twitter and Instagram, and the 60-second versions are available on CalOptima's website. The full collection is on YouTube at CalOptima TV. Further, we debuted the videos with provider and community partners via our weekly Community Announcements newsletter. Communications also shared the videos with the County, which plans to distribute the material to the Consulate of Mexico in Santa Ana, Catholic Charities & Catholic Diocese, 2T Vietnamese Media and Viet Links. CalOptima will continue to seek broad channels to use the messages in reaching the vaccine hesitant.

**Legislative Platform Priorities Lead to Letters of Support for Coordinated Re-Entry Center, Be Well Campus South**
Signed into law March 11, the American Rescue Plan Act includes $350 billion for state and local governments. This includes $621 million for Orange County and the Community Project (Earmark) Funding program. In alignment with the County of Orange and CalOptima's 2021–22 Legislative Platform priorities, CalOptima submitted letters of support in support of the County's request for an allocation of $10 million for the following programs:

- Coordinated Re-Entry Center: $5 million to support a central location for individuals released from or involved in the criminal justice system that offers 24/7 access to services, such as job training and placement, housing and public assistance, and physical and mental health care.
- Orange County Behavioral Wellness (Be Well) Campus South: $5 million to support clinical and residential services for mental illness and substance use once the campus is operational.

**All Hands Guest Speaker to Focus on Unconscious Bias, Diversity, Equity and Inclusion**
CalOptima's quarterly All Hands meeting for employees remains in a virtual format and is planned for May 19. In addition to the regular updates from leaders, the meeting will feature

guest speaker Dr. Shirley Davis presenting on the topic of unconscious bias and its impact on decision-making. She is an accomplished workforce management expert known for offering engaging training sessions on diversity, equity and inclusion. She has more than 25 years of business experience in executive roles with Fortune 100 companies. Dr. Davis is the president of SDS Global Enterprises, a consulting firm that specializes in strategies for achieving leadership excellence and building inclusive workplace cultures.

**CalOptima CEO Invited to Community Presentations**
On a regular basis, I am asked to present at health and community events. Below are three recent opportunities:

- *Health and Housing Policy Forum*: On April 16, the UCI School of Social Ecology, Master of Public Policy program and the Public Policy Student Association partnered with American Family Housing to present a virtual forum on the intersection of health and housing. I spoke on a panel about CalOptima's efforts around social determinants of health (SDOH) and the upcoming Medi-Cal changes under CalAIM. The panel was titled "Bridging the Policy Divide: Integrating Health and Housing."
- *Orange County United Way:* On April 29, Orange County United Way's United for Financial Security initiative hosted a "Keeping It Real OC" session focused on SDOH. I was a panelist alongside two other leaders in discussing the impact of economic, social and other challenges on health outcomes.
- *South County Senior Summit:* With your Board's approval of CalOptima's sponsorship of the South County Senior Summit, I taped remarks for the televised event that will air on Cox Communications' Channel 39 twice a day during May. Further, CalOptima also supplied our animated videos about the Member Health Rewards and what to do after vaccination.

# COVID-19 Update & Outreach Efforts

Board of Directors Meeting
May 6, 2021

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

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# COVID-19 Efforts in Progress

- Member Vaccination Strategy
  - Number of members vaccinated
  - Eligibility opens up to 16 and older (as of April 15)
  - Texting campaign

- Member Incentive Implementation
  - Number of gift cards sent

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# COVID-19 Outreach Efforts

- **Outreach Dates**
  - Telephonic outreach between February 23rd and March 5th
- **26 total staff made outreach efforts**
  - 21 Personal Care Coordinators (PCCs) and Medical Assistants (MAs)
  - 5 Registered Nurses (RNs)
- **Over 5400 total calls made**
  - Three-call attempt maximum to reach members
- **2885 total members outreached**
  - 1669 total successful contacts
  - 1216 total members unable to contact

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# The Outreach Population

Members

- Assigned to CalOptima Community Network
- Aged 65 and over
- Not assigned to a Federally Qualified Health Center (FQHC) or Community Clinic as their PCP
- All areas of Orange County

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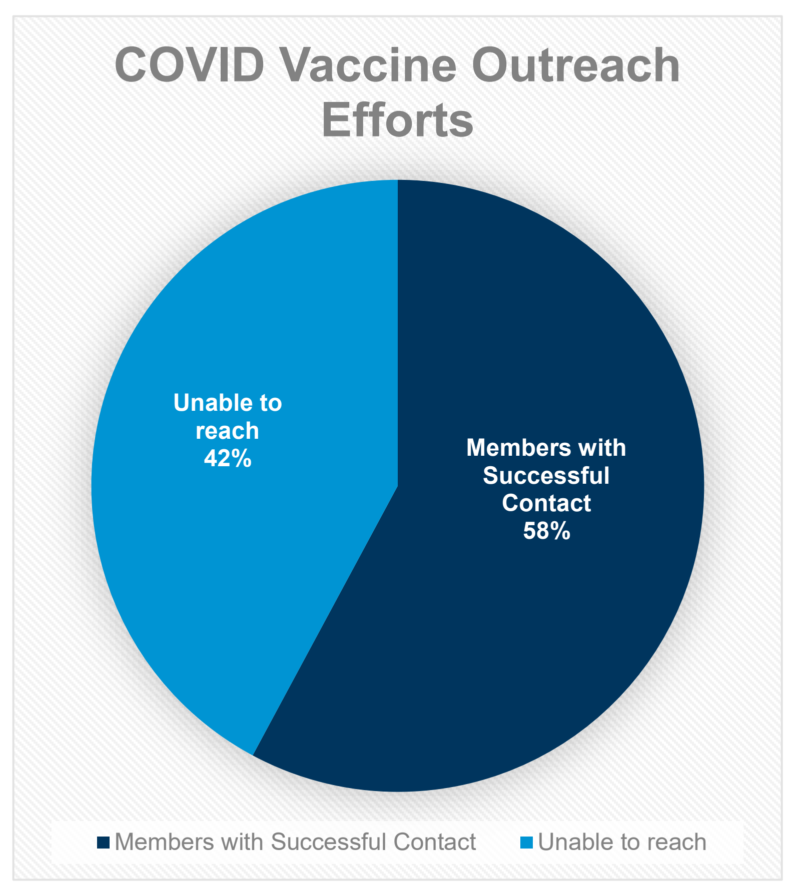
# Total members outreached

- 2885 – Total Members outreached
- 1669 – **(58%)** Members with a successful contact
- 1216 – **(42%)** Members unable to reach

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# Successful Contact Outcome

- 1669 – Total successful contacts
- 880 – **(53%)** Members had already received the vaccine or were already scheduled to receive it
- 789 – **(47%)** Members had **not** yet received the vaccine or were not already scheduled

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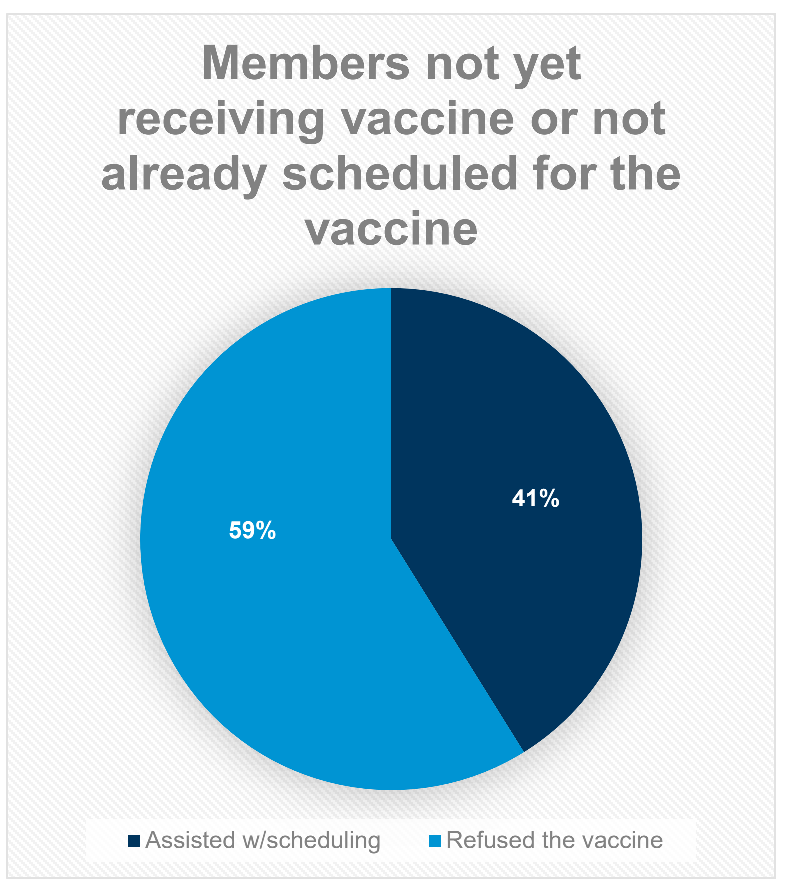
# Members not yet receiving or being scheduled for the vaccine

- 789 – Total members who had not yet received or scheduled vaccine appointments
- 320 – (41%) Members were assisted with scheduling vaccine appointments
- 458 – (27% of members reached/58% of members who had not received vaccine) Members **refused** assistance with scheduling vaccine appointments

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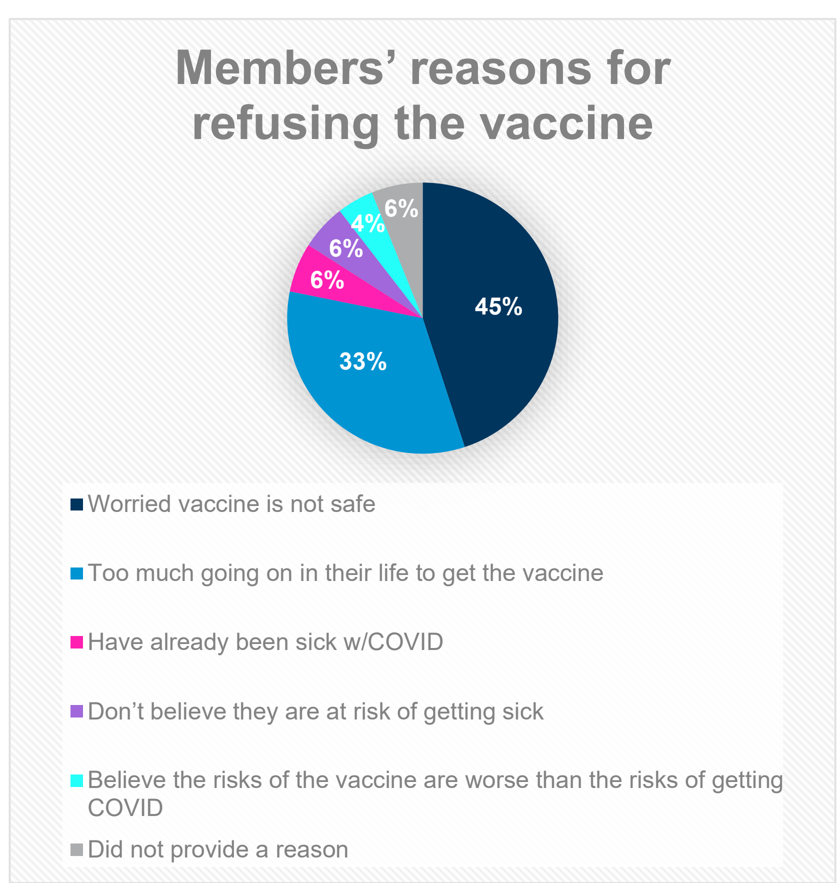
# Members' reasons for refusing assistance with scheduling

- **458** – Total members refusing assistance
- 206 – **(45%)** Worried vaccine is not safe
- 152 – **(33%)** Too much going on in their life to get the vaccine
- 27 – **(6%)** Have already been sick with COVID-19
- 25 – **(5%)** Don't believe they are at risk of getting sick
- 20 – **(4%)** Believe the risks of the vaccine are worse than the risks of getting COVID-19
- 28 – **(6%)** Did not provide a response

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# Lessons Learned

- Majority of members had received or had been scheduled to receive the vaccine
- Scheduling can prove difficult to navigate for members
- Language was a barrier for some in accessing appointments

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# Our Mission

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

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# Introduction to the FY 2021-22 CalOptima Budget: Part 2

Board of Directors Meeting
May 6, 2021

Nancy Huang, Chief Financial Officer

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# FY 2021-22 Budget Overview

- Enrollment Trends
  - Increase in Medi-Cal TANF Adult and Expansion members
  - Increase in OneCare Connect
  - Increase in OneCare and PACE

- Base Rate Assumptions (CY 2022 vs. CY 2021)
  - Medi-Cal Classic: Increase of 2%
  - Medi-Cal Expansion: Decrease of 3%
  - Medi-Cal WCM: Decrease 1%
  - Medi-Cal Dual eligibles: Utilized CY 2021 rates
  - Medicare Revenue (OneCare Connect, OneCare, PACE): Slight increase, in aggregate

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# FY 2021-22 Budget Overview (cont.)

- Program Updates
  - January 2022:  Anticipated date for Medi-Cal Rx carve-out
  - January 2022:  MSSP carve-out of Medi-Cal

- Operational Updates
  - July 2021:  FFS reimbursement changes
  - July 2021:  Medi-Cal Expansion capitation adjustments
  - July 2021:  Medi-Cal Classic capitation adjustments
  - July 2021:  Medi-Cal WCM capitation adjustments

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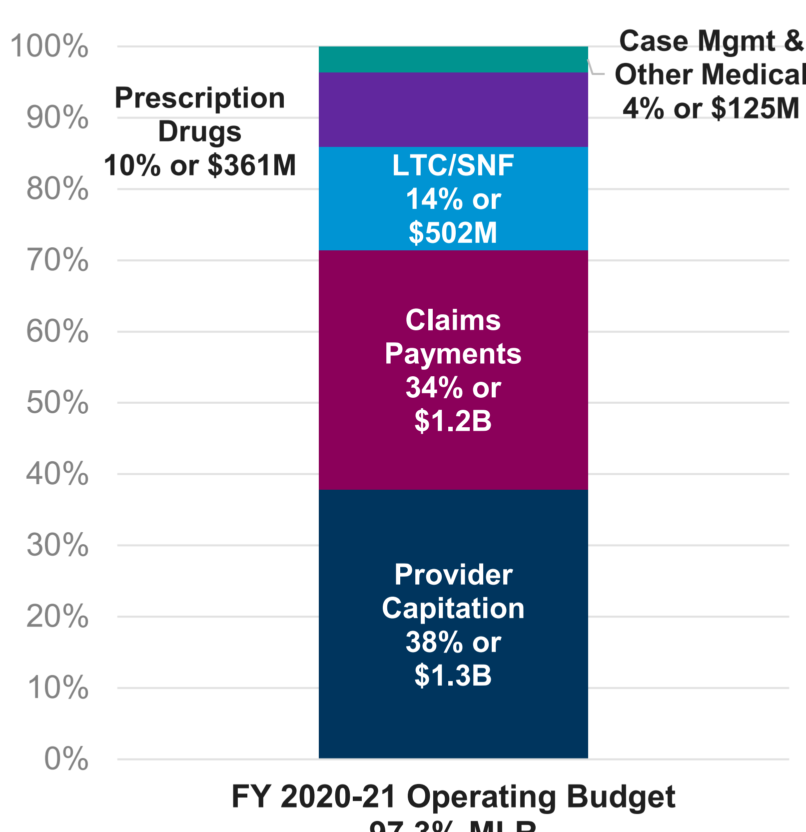
# Operating Budget: Medical Costs

- Goal: Maximize quality and access for members
- Driven primarily by program, utilization, unit cost and service mix
- Looking ahead:
  - Provider rate adjustments
  - Medi-Cal Rx carve-out
  - CalAIM – ECM and ILOS
  - MSSP carve-out
  - Telehealth flexibilities
  - Effects of COVID pandemic




Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

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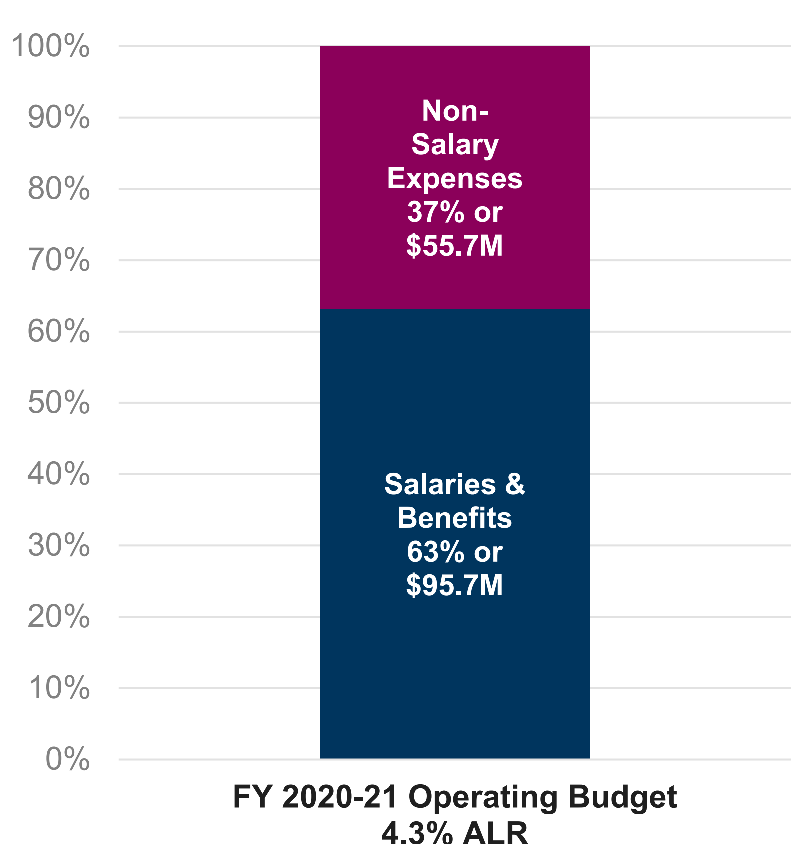
# Operating Budget: Administrative Expenses

- Personnel levels dependent on membership, utilization level and regulatory requirements
- Initial budget forecast based on 12-month historical run-rate
- Internal departments review contract obligations and additional resource requirements
- Sr. Management reviews and approves their departments' budgets




Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

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# Operating Budget: Administrative Expenses – Looking Ahead

- Salaries, wages & employee benefits
  - Updated salary schedule (Board action on 3/4/21)
  - New position, upgrade and temporary help requests and merit increase
  - Proposed decrease in vacancy factor percentage based on current year actuals
- Non-Salary Expenses
  - Professional fees (e.g., legal fees, internal and regulatory audits, consulting, strategic planning)
  - New member communication initiatives
  - Increase in contingency contracts and claims recovery services
  - Information Services support and new maintenance costs

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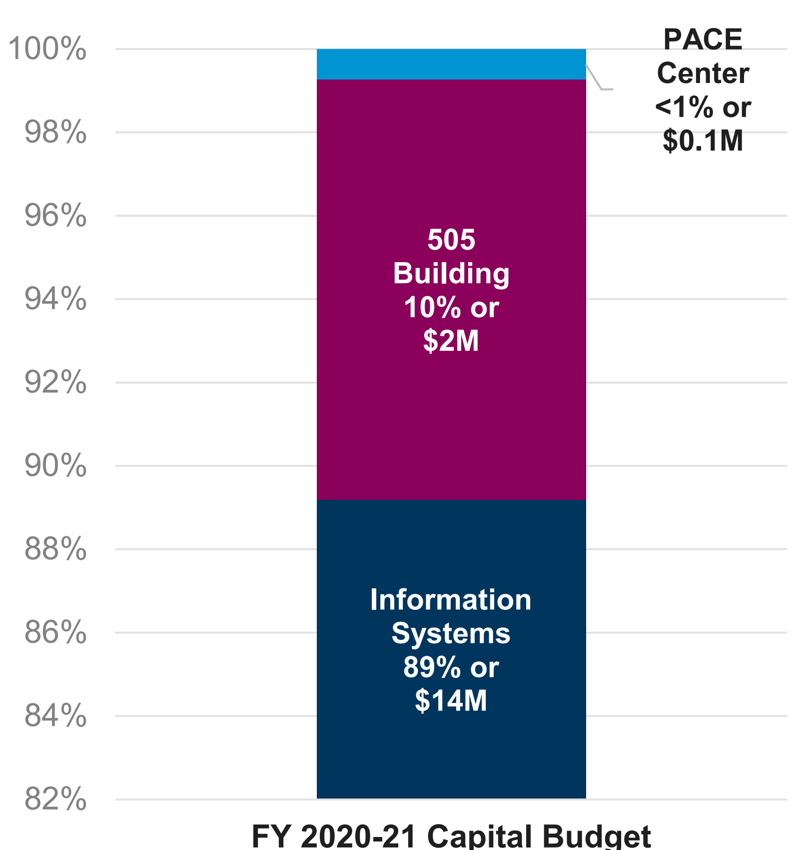
# Capital Budget Overview

- Internal departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests
- Looking ahead:
  - Information Services infrastructure, application management and application development
  - Office improvements and other building needs




Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

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# Board Approval Timeline

| | Date | Meeting |
|---|---|---|
| √ | February 18, 2021 | Finance and Audit Committee meeting: Present background information on FY 2021-22 Budget Primer |
| √ | April 1, 2021 | Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 1 |
| | May 6, 2021 | Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 2 |
| | May 20, 2021 | Finance and Audit Committee meeting: Present FY 2021-22 budgets |
| | June 3, 2021 | Board of Directors meeting: Present FY 2021-22 budgets |
| | July 1, 2021 | Beginning of Fiscal Year 2021-22 |

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# Our Mission

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

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# MINUTES

## Regular Meeting
## of the
## CalOptima Board of Directors

**April 1, 2021**

A Regular Meeting of the CalOptima Board of Directors was held on April 1, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:00 p.m. and Vice Chair Becerra led the Pledge of Allegiance.

**ROLL CALL**

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D. (At 2:05 p.m.)
(All Board Members participated remotely except Chairman Do and Director Jordan, who attended in person)

Members Absent: None.

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

**PRESENTATIONS/INTRODUCTIONS**

None.

**MANAGEMENT REPORTS**

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, announced that Dr. Emily Fonda is CalOptima's new Chief Medical Officer and no longer serving in an interim capacity. Mr. Sanchez also updated the Board that staff has been working with the CalOptima Member Advisory Committee and Provider Advisory Committee and plans to provide an update on Strategic Initiatives at the June Board meeting.
Mr. Sanchez also noted that, based on direction provided at the March 4 Board meeting, he had sent out information to the Board regarding CalOptima's financials and asked Board members to follow up with him if they had any questions on the information provided.

2. Chief Medical Officer Updates

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update.

3. California Advancing and Innovating Medi-Cal (CalAIM) Update

Rachel Selleck, Executive Director, Public Affairs, provided background on the CalAIM initiative, including references to the Whole Person Care (WPC) pilot program that was initiated in 2016. In

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Orange County, the WPC focused on the homeless Medi-Cal population and included services such as housing navigation and recuperative care. In 2020 CalOptima launched the Health Homes Program (HHP) in Orange County. Ms. Selleck added that the services now provided through the WPC and HHP programs are to be included as part of CalAIM as Enhanced Care Management (ECM) and In Lieu of Services (ILOS). Proposals from health plans for the first phase are due to the state in July 2021, with an implementation target of January 2022. Staff plans to return to the Board with recommendations and additional details at future Board meetings.

4. Introduction to the FY 2021-22 CalOptima Budget: Part 1
Nancy Huang, Chief Financial Officer, provided an overview of the FY 2021-22 CalOptima Budget and next steps in the planning process, including follow up presentations with additional details to the Board and to the Board's Finance and Audit Committee ahead of staff returning to the Board with recommendations for approval at its regular June meeting.

**PUBLIC COMMENTS**

1. Thomas Fielder – Oral re: Vaccinations for members experiencing homelessness

**CONSENT CALENDAR**

5. Minutes

   a. Approve Minutes of the March 4, 2021 Regular Meeting of the CalOptima Board of Directors

   b. Receive and File Minutes of the October 22, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee and the Minutes of the December 10, 2020 Special Joint Meeting of the Member Advisory, Provider Advisory, OneCare Connect Member Advisory and the Whole-Child Model Family Advisory Committees

6. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee increasing the size from three seats to four seats

7. Consider Modifications to CalOptima Pharmacy Management Policies and Procedures in connection with CalOptima's regular review process and consistent with regulatory requirements to Policies MA.6106 Medication Therapy Management [OneCare, OneCare Connect] and GG.1401 Pharmacy Authorization Process [Medi-Cal]

8. Consider Actions Related to COVID-19 Vaccines for CalOptima Direct and CalOptima Community Network Members with AltaMed Health Services Corporation, Rx Consultants Group, Inc., and Community Health Centers: Ratify a.) Amendment to the AltaMed Health Services Corporation Fee-For-Service Physician Medi-Cal Contract, reflecting new terms for administration of the COVID-19 vaccine to CalOptima Direct and CalOptima Community Network members; b.) Memorandum of Understanding with Rx Consultants Group, Inc. (Mercy Medical Center Pharmacy), for the provision of COVID-19 vaccines to CalOptima members; and Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Fee-For-Service Physician Medi-Cal Contracts of all Community Health Centers to reflect new

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terms for administration of the COVID-19 vaccine to CalOptima Direct-Administrative and CalOptima Community Network members, based on their eligibility to administer the vaccine
Vice Chair Becerra did not participate in this item due to her affiliation with the Coalition of Orange County Community Health Centers. Director Jordan did not participate in this item due to his affiliation with Providence St. Joseph Health Care. Director Schoeffel did not participate in this item due to potential conflicts of interest.

9. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event: Authorize expenditures up to $10,000 for Age Well Senior Services, Inc. Virtual Senior Summit 2021 "Safe and Healthy Senior Living in the Age of COVID-19" in May 2021; Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures

10. Receive and File
- a. February 2021 Financial Summary
- b. Compliance Report
- c. Federal and State Legislative Advocates Reports
- d. CalOptima Community Outreach and Program Summary

***Action:*** ***On motion of Director Corwin, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 6-0-0; Vice Chair Becerra; Directors Jordan and Schoeffel absent)***

**REPORTS**

11. Consider Ratification of Contract with Medical Review Institute of America, LLC (MRIoA) for Clinical Medical Record Review Services and Reallocate Budgeted but Unspent Salary Dollars to Fund These Services; Ratify contract with MRIoA, effective March 1, 2021, through June 30, 2021, to support timely and compliant completion of authorization requests, appeals, peer reviews and special investigations; and Authorize reallocation of budgeted but unused funds of up to $120,000 from Medical Management – Salaries to Medical Management – Professional Fees to support services provided by MRIoA through June 30, 2021

***Action:*** ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Ratified contract with Medical Review Institute of America, LLC (MRIoA), effective March 1, 2021, through June 30, 2021, to support timely and compliant completion of authorization requests, appeals, peer reviews and special investigations; and 2.) Authorized reallocation of budgeted but unused funds of up to $120,000 from Medical Management – Salaries to Medical Management – Professional Fees to support services provided by MRIoA through June 30, 2021 (Motion carried 9-0-0)***

12. Consider Approval of CalOptima's 2021–22 Legislative Priorities and 2021–22 Legislative Platform; Adopt CalOptima's 2021–22 Legislative Priorities; Adopt CalOptima's 2021–22 Legislative Platform; and Authorize the Chief Executive Officer, or designee, to implement legislative advocacy

efforts in alignment with the 2021–22 Legislative Priorities and Legislative Platform and provide regular progress reports to the Board of Directors

***Action:*** ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1.) Adopted CalOptima's 2021–22 Legislative Priorities; 2.) Adopted CalOptima's 2021–22 Legislative Platform; and 3.) Authorized the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the 2021–22 Legislative Priorities and Legislative Platform and provide regular progress reports to the Board of Directors. (Motion carried 9-0-0)***

The recommended actions for Agenda Items 13 through 14 were each read into the record and were approved in a single motion and vote.

13. Consider Receiving and Filing CalOptima's 2020 Quality Improvement Program Evaluation
Marie Jeannis, Interim Executive Director, Quality and Population Health Management introduced this item.

***Action:*** ***On motion of Director Jordan, seconded and carried, the Board of Directors received and filed the 2020 CalOptima Quality Improvement Program Evaluation. (Motion carried 8-0-0; Director Schoeffel absent)***

14. Consider Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan
Ms. Jeannis provided an overview the proposed CalOptima 2021 Quality Improvement Program and Quality Improvement Work Plan.

***Action:*** ***On motion of Director Jordan, seconded and carried, the Board of Directors approved the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan. (Motion carried 8-0-0; Director Schoeffel absent)***

**ADVISORY COMMITTEE UPDATES**

15. Joint Meeting of the Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and Whole-Child Model Family Advisory Committees Update
Patty Mouton, Chair, OneCare Connect Member Advisory Committee, provided an overview of the activities at the Joint Meeting of the Advisory Committees.

16. Whole-Child Model Family Advisory Committee Update
Kristen Rogers, Chair, Whole-Child Model Family Advisory Committee (WCM FAC), provided an overview of the WCM FAC activities.

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**

Chairman Do appointed Director Shivers to fill the vacancy on the Quality Assurance Committee (QAC), serving along with QAC Chair Giammona and Director Tran. In addition, following the Board's action today to add a fourth seat to the Finance and Audit Committee (FAC), Chairman Do

appointed Director Jordan to that seat and serve along with FAC Chair Becerra, Director Corwin, and Director Schoeffel.

Board members congratulated Dr. Fonda on her appointment as Chief Medical Officer.

Hearing no further business, Chairman Do adjourned the meeting at 4:21 p.m.

**ADJOURNMENT**

*/s/ Sharon Dwiers*
Sharon Dwiers
Clerk of the Board

*Approved: May 6, 2021*

# MINUTES

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

**February 11, 2021**

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on February 11, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

**CALL TO ORDER**

PAC Chair Dr. Junie Lazo-Pearson, called the meeting to order at 8:00 a.m. and led the Pledge of Allegiance.

**ESTABLISH QUORUM**

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D; Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; John Kelly, M.D.; Peter Korchin; Teri Miranti; Loc Tran, PharmD.; Christy Ward

Members Absent: Tina Bloomer, MHNP; Alexander Rossel

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Interim Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Rachel Selleck, Executive Director, Public Affairs; Pallavi Patel, Director, Process Excellence; Cheryl Simmons, Staff to the Advisory Committees; Wilber Sham, Senior Customer Service Representative; Kathi Porcho, Administrative Assistant, Provider Relations

**MINUTES**

**Approve the Minutes of the November 12, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee.**

***Action:*** ***On motion of Member Dr. Alpesh Amin, seconded and carried, the Committee approved the minutes of the November 12, 2020 regular meeting. (Motion carried 13-0-0; Members Bloomer and Rossel absent)***

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**Approve the Minutes of the December 10, 2020 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee.**

***Action:*** ***On motion of Member Christy Ward, seconded and carried, the Committee approved the minutes of the December 10, 2020 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and the Whole-Child Model Family Advisory Committee. (Motion carried 13-0-0; Members Bloomer and Rossel absent)***

## PUBLIC COMMENTS

There were no public comments.

## CEO AND MANAGEMENT REPORTS

### Chief Executive Officer Update

Richard Sanchez, Chief Executive Officer, notified the Committee that the Board, at its February 4, 2021 meeting, requested that the PAC, along with the other Board Advisory Committees, review certain items as part of an update to the current Strategic Plan. Mr. Sanchez also notified the PAC that Nancy Shivers had been appointed by the Orange County Board of Supervisors to serve as the new Member Representative on the CalOptima Board and would begin her term at the March 4, 2021 Board meeting.

### Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, informed the PAC that of the approximately 1,000 members who had received information through the mail on their possible eligibility for the Qualified Medicare Beneficiary (QMB) program that CalOptima had received approximately a 40% response back to date from these mailings.

### Chief Medical Officer Update

Emily Fonda, M.D., Interim Chief Medical Officer, provided an update on the current status of the E-Consult/Telehealth program.

## INFORMATION ITEMS

### COVID–19 Update

Dr. Fonda provided an overview of CalOptima's COVID-19 Vaccine and Member Outreach Strategy and outreach efforts to approximately 806,000 CalOptima members. Dr. Fonda also provided an update on the Orange County Nursing Home Program, which started in June 2020. In addition, Dr. Fonda reported on the Virtual Urgent Care Pilot, noting that virtual care is available regardless a members' network assignment for behavioral health conditions, and non-behavioral health care for the CalOptima Care Network. Dr. Fonda added that the goal of the

pilot is to mitigate access and availability issues that many provider offices have been experiencing during the pandemic.

**Strategic Plan Update**

Rachel Selleck, Executive Director, Public Affairs, presented on the CalOptima 2020-2022 Strategic Plan Review Session. Ms. Selleck reviewed the process that was undertaken between April and December 2019 to formulate updates to the current strategic plan that was approved by the previous Board in December 2019. She noted that one of the strategic objectives was to utilize strong advisory committee participation as part of the strategic plan update process. Per direction from the Board at its February 4, 2021 meeting, CalOptima staff will engage the advisory committees regarding proposed goals for behavioral health, health equity, possible service delivery model refinements, and social determinants of Health. She also commented that the members of the advisory committees will have an opportunity to review and discuss the strategic objectives at the Special Joint Committee meeting scheduled for March 11, 2021 and provided PAC members with a Strategic Priority Initiatives handout.

**Federal and State Legislative Update**

Ms. Selleck provided an update on several legislative items of interest to the committee and noted that the State Legislature had delayed the start of the new session until January 11, 2021 due to the increase in positive COVID-19 cases in the State.

**CHE Behavioral Health Services: Meeting the Mental Health Service Needs of Persons in the Community and Long-Term Care Settings**

Jennifer Birdsall, Ph.D., Chief Clinical Officer, CHE Behavioral Health Services, and PAC's Allied Health Representative, presented an overview of the services offered by CHE Behavioral Health Services and discussed behavioral health services offered to members in long-term care facilities. Dr. Birdsall also discussed their use of outpatient teletherapy services and discussed the mental health impact of COVID-19 on these members.

**California Advancing and Innovating Medi-Cal (CalAIM) Update**

Pallavi Patel, Director, Process Excellence, provided a verbal report on how CalAIM has been put back into the State budget and is expected to begin on January 1, 2022. Ms. Patel noted that more information would be forthcoming at the joint meeting on March 11, 2021.

**PAC Member Updates**

Chair Lazo-Pearson noted that PAC will begin its annual recruitment in March for seats that expire on June 30, 2021. The current appointments to the following seats are expiring: Allied Health Services Representative, Behavioral/Mental Health Representative, Health Network Representative and Nurse Representative. She also noted that the next meeting would be a joint meeting on March 11, 2021 at 9:00 AM with the other Board Advisory Committees.

**ADJOURNMENT**
Hearing no further business, Chair Lazo-Pearson adjourned the meeting at 9:36 a.m.

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

*Approved: April 8, 2021*

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# MINUTES

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

February 11, 2021

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on February 11, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

**CALL TO ORDER**

Chair Tolbert called the meeting to order at 2:32 p.m. and led the Pledge of Allegiance.

**ESTABLISH QUORUM**

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Maura Byron; Sandra Finestone; Connie Gonzalez; Jacqueline Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Melisa Nicholson; Kate Polezhaev; Sr. Mary Therese Sweeney; Steve Thronson

Members Absent: Mallory Vega

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Interim Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Jackie Marks, Sr. Policy Advisory, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Wilber Sham, and Jorge Dominguez, Customer Service.

**MINUTES**

**Approve the Minutes of the November 12, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee**

*Action:* ***On motion of Member Maura Byron, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 13-0-0, Member Vega absent)***

**Approve the Minutes of the December 10, 2020 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee**

*Action:* ***On motion of Member Steve Thronson, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 13-0-0, Member Vega absent)***

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**PUBLIC COMMENT**
There were no public comments.

**REPORTS**

**Consider Recommendation of Medi-Cal Beneficiaries Representative Seat**
Steve Thronson reviewed on behalf of the Nominations Ad Hoc Committee the recommendation of Linda Adair Pugh as the Medi-Cal Beneficiaries Representative. He noted that Ms. Adair Pugh is retired and a current CalOptima Medi-Cal member. Ms. Adair Pugh has lived in the Orange County area for more than 50 years where she currently sits on two different boards for the City of Anaheim: she serves on the Residential Advisory Board and is also a Commissioner on the Housing and Community Development Commission.

***Action:*** ***On motion of Member Patty Mouton, seconded and carried, the Committee approved the recommendation of Linda Adair Pugh as the Medi-Cal Beneficiaries Representative (Motion carried 13-0-0, Member Vega absent)***

**CEO AND MANAGEMENT REPORTS**

**Chief Executive Officer Update**
Richard Sanchez, Chief Executive Officer notified the MAC that Nancy Shivers had been chosen as the new Member Representative on the Board and would begin her term at the March 4, 2021 Board meeting. He also notified the members that the Board at their February 4, 2021 meeting requested that the MAC and the PAC along with the other Board Advisory Committees review certain items as part of an update to the current Strategic Plan.

**Chief Operating Officer (COO) Update**
Ladan Khamseh, Chief Operating Officer informed the MAC that of the approximately 1,000 members that had received information on their possible eligibility for the Qualified Medicare Beneficiary (QMB) program to claim Part A Medicare benefits, approximately 400 members who were eligible responded back to CalOptima.

*Due to audio difficulties for VI.C., Chair Tolbert rearranged the agenda to hear VII.A.*

**INFORMATION ITEMS**

**MAC Member Updates**
Chair Tolbert announced that MAC recruitment for seats expiring on June 30, 2021 would begin in March. Current MAC seats coming up for recruitment include: Adult Beneficiaries, Family Support, Persons with Disabilities and Seniors Representatives. She also reminded the committee that there would be a special joint meeting on March 11, 2021 at 9:00 a.m. with all the advisory committees.

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**COVID-19 Update**
Emily Fonda, M.D., Interim Chief Medical Officer (CMO) who had experienced technical difficulties during her CMO update combined both items and presented on the current status of COVID-19 in Orange County. Dr. Fonda explained how the outreach effort on vaccine availability for the more than 806,000 CalOptima members. Dr. Fonda also discussed the Virtual Urgent Care Pilot program and how virtual care was available regardless of network assignment for behavioral health conditions and non-behavioral health conditions for the CalOptima Care Network. She also noted that the goal was to assist with access and availability issues currently being experienced by provider offices with limited capacity during the pandemic.

**Strategic Plan Update**
Debra Kegel, Director, Strategic Development presented on the CalOptima 2020-2022 Strategic Plan Review Session. Ms. Kegel reviewed the process that was undertaken between April and December 2019 to formulate updates to the current strategic plan that was approved by the previous Board in December 2019. She noted that one of the strategic objectives was to utilize strong advisory committee participation as part of the strategic plan update process. Per direction from the Board at its February 4, 2021 meeting, CalOptima staff will engage the advisory committees regarding proposed goals for behavioral health, health equity, possible service delivery model refinements, and social determinants of Health. She also commented that the members of the advisory committees will have an opportunity to review and discuss the strategic objectives at the Special Joint Committee meeting scheduled for March 11, 2021 and provided MAC members with a Strategic Priority Initiatives handout.

*Due to further audio difficulties, Chair Tolbert rearranged the agenda to hear agenda item VII. E before returning to agenda item VII.D.*

**Children with Intellectual/Developmental Disabilities – Reaching the Underserved**
Hai Hoang, Chief Operating Officer, Illumination Institute and MAC member representing Persons with Disabilities presented on the Illumination Institute's mission and how in partnership with Children's Hospital Orange County, Children's Hospital Los Angeles, University of Irvine and the University of Southern California were identifying gaps in care knowledge pertaining to pediatric oncology and survivorship care and how to solve them. He noted that a community and resource linkage mobile app was currently in development to assist with this endeavor. Mr. Hoang also discussed how they used mindfulness techniques in schools and children with intellectual/ developmental disabilities as well as a parent mentoring program. He also noted that the parent mentoring program was in coordination with the Regional Center of Orange County (RCOC) and included parent education and mentoring families how to use CalOptima services.

**Community Relations Update**
Tiffany Kaaiakamanu, Manager, Community Relations presented on how Community Relations has transitioned their outreach and education efforts in the community during the COVID-19 pandemic. She noted that approximately 41 community events/resource fairs had to be cancelled or postponed between March and May 2020. She also noted that since March 2020, the Community Relations Department had been following local, state and federal guidelines to slow the spread of

COVID and continued to support the community by attending 35 virtually meetings on a regular basis, provided CalOptima Medi-Cal presentations via virtual platforms and hosted virtual events for community partners and staff, such as the Community Alliances Forum and Virtual Resource Fair. She also noted that CalOptima continued to provide financial support to these virtual community events and would seek the Board's approval as needed, in compliance with policy guidelines.

**Federal & State Legislative Update**
Jackie Mark, Sr. Policy Advisor provided an update on several legislative items of interest and noted that the COVID-19 is still the top priority at the Federal level. Ms. Mark referred the members to the handout in their meeting materials for other items of interest.

**Committee Member Comments**
Maura Byron, Family Support Representative updated the committee on how the Family Support Network are rolling out their new Voice Options program. Family Support has partnered with the Department of Rehabilitation to supply free iPads loaded with communication applications for individuals with language disabilities. They are working with a speech pathologist to identify and assist these individuals.

Connie Gonzalez, Social Services Representative told the members that the Social Services office has reopened for limited hours and that they have a service center that is taking calls on Saturday. Individuals are able to sign up calling 800-281-9799. Phone hours have been extended during this time.

Sally Molnar, Medical Safety Net Representative reminded everyone about the importance of getting necessary screenings even during this time of COVID-19.

Patty Mouton, Long-Term Services and Supports Representative notified the members that Alzheimer's Orange County partnering with the Orange County Health Care Agency had opened a facility at Fairview Developmental Center in Costa Mesa for those members who suffer from Alzheimer's and dementia to receive in-patient care when they test positive for COVID-19 at no charge for services.

**ADJOURNMENT**
Hearing no further business, Chair Tolbert adjourned the meeting at 4:45 p.m.

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

*Approved: April 8, 2021*

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*Continued to a Future Meeting*

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

5. Consider Approval of Modifications to CalOptima Medical Affairs Policies and Procedures

**Contact**

Emily Fonda, M.D., Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, (714) 246-8549

**Recommended Action**

Approve recommended modifications to the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. Policy GG.1102: Experimental and Investigational Service Coverage
2. Policy GG.1301: Comprehensive Case Management Process
3. Policy GG.1313: Coordination of Care for Transplant Members

**Background/ Discussion**

CalOptima regularly reviews its Policies and Procedures to ensure they are up to date and aligned with Federal and State health care program requirements, contractual obligations and laws, as well as CalOptima operations.

Below is information regarding the policies that require modification:

1. **Policy GG. 1102: Experimental and Investigational Service Coverage** defines the benefit coverage for Experimental and Investigational Services under the CalOptima program. Modifications to the policy include addition of criteria specific to coverage of these services for Whole-Child Model members as required by the Department of Health Care Services, updated references, and edits to the glossary.

2. **Policy GG.1301: Comprehensive Case Management Process** defines the guidelines for Case Management of Members enrolled in the Medi-Cal program, by CalOptima or a Health Network. Revisions were made to reflect updated National Quality Assurance Committee (NCQA) Standards for Complex Case Management, including assessment and evaluation of a member's social determinants of health and barriers to care, and how eligibility criteria and referral processes are communicated to providers and members. Whole-Child Model and Health Homes policy statements were added, as well as a reference to case management requirements for children and youth receiving Private Duty Nursing as outlined in CalOptima Policy GG.1352: Private Duty Nursing Care Management.

3. **Policy GG.1313: Coordination of Care for Transplant Members** defines the Case Management guidelines for coordination of care by CalOptima and a Health Network for a member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ Transplant.

Updates to the policy included the addition of terms specific to pediatric transplant facilities, removal of a 90-day time frame for completion of transplant evaluation, clarification that Kaiser is responsible for transplant authorization for their assigned members, and updates to the glossary of terms.

**Fiscal Impact**

The recommended action to authorize the CEO to revise CalOptima Policies GG.1102, GG.1301 and GG.1313 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

**Rationale for Recommendation**

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede prior versions.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Policy GG. 1102: Experimental and Investigational Service Coverage (Redlined and Clean versions)
2. Policy GG.1301: Comprehensive Case Management Process (Redlined and Clean versions)
3. Policy GG.1313: Coordination of Care for Transplant Members (Redlined and Clean versions)

*/s/ Richard Sanchez* | *04/29/2021*
**Authorized Signature** | **Date**

| | |
|---|---|
| Policy: | GG.1102 |
| Title: | **Experimental and Investigational Service Coverage** |
| Department: | Medical Management |
| Section: | Utilization Management |
| *CEO Approval*: | |
| Effective Date: | 02/01/2002 |
| Revised Date: | TBD |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☒ OneCare Connect<br>☐ PACE<br>☐ Administration |

For 20210506 BOD Review Only

## I. PURPOSE

This policy defines the benefit coverage for Experimental and Investigational Services under the CalOptima program.

## II. POLICY

A. Experimental Services are not covered under the Department of Health Care Services (DHCS) Medi-Cal program, Whole Child Model (WCM) program, or the Centers for Medicare & Medicaid Services (CMS) Medicare or Duals Demonstration programs~~.~~, except as specified in this Policy or specifically authorized by law.

B. Coverage of Investigational Services in the Medi-Cal program

1. Investigational Services require Prior Authorization, and are covered when it is clearly documented that all of the following apply:

a. The Member has a life threatening or seriously debilitating disease or medical condition;

b. There is a medically reasonable expectation that the Investigational Service will significantly prolong the intended Member's life or will maintain or restore a range of physical and social function suited to Activities of Daily Living (ADL);

c. Conventional therapy will not prevent progressive disability or premature death, nor adequately treat the intended Member's condition;

d. The provider of the proposed service has a record of safety and success, which is equivalent or superior to that of other providers of the Investigational Service; ~~and~~

e. The Investigational Service is the lowest cost item or service that meets the Member's medical needs and is less costly than all conventional alternatives; and

~~e.~~f. The service is not being performed as a part of a research study protocol.

C. Coverage of Investigational Services in the OneCare and OneCare Connect programs

1. Category A and Category B Investigational Device Exemption (IDE) studies require Prior Authorization, and are covered when the following requirements are met:

   a. The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients;

   b. The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c. The study results are not anticipated to unjustifiably duplicate existing knowledge;

   d. The study design is methodologically appropriate, and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study;

   e. The study is sponsored by an organization or individual capable of successfully completing the study;

   f. The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in Title 21 of the Code of Federal Regulations (CFR), Parts 50, 56, and 812, and Title 45, CFR., Part 46;

   g. Where appropriate, the study is not designed to exclusively test toxicity, or disease pathophysiology, in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one (1) of the objectives may be exempt from this criterion, only if the disease or condition being studied is life threatening and the patient has no other viable treatment options;

   h. The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov;

   i. The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes, and that the release should be hastened if the study is terminated early; and

   j. The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.

D. CalOptima shall cover cancer Clinical Trials, in accordance with CalOptima Policy GG.1125: Cancer Clinical Trials.

E. Coverage for routine costs of qualifying Clinical Trials are covered upon approval by the Chief Medical Officer (CMO~~), ~~,) or his or her Designee, unless the coverage of the service is otherwise defined as a non-covered service or item in Title 22, California Code of Regulations (C.C.R~~), or Title 42, United States Code (U.S.C.), Section 300gg-8.~~).

F. Coverage for Clinical Trials is restricted to participating hospitals and physicians in California, unless the protocol for the Clinical Trial is not provided for at a California hospital or by a California physician.

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G. For the Medi-Cal ~~programs~~program, CalOptima~~,~~ or a Health Network~~,~~ shall provide coverage for routine costs for Investigational Services associated with a Clinical Trial, if the Clinical Trial meets the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within the benefit category of the Medicaid/Medicare program (e.g., Physician's service, Durable Medical Equipment (DME), diagnostic test) and are not ~~be~~ statutorily excluded from coverage (e.g., cosmetic surgery).

2. The trial must not be designed exclusively to test toxicity, or disease pathophysiology. It must have therapeutic intent and be considered a Phase III Clinical Trial in the United States.

3. Trials of therapeutic interventions must enroll patients with a diagnosed disease, rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients, in order to have a proper control group.

H. The requirements in Section II.G. of this ~~policy~~Policy are insufficient by themselves to qualify a Clinical Trial for the Medicare Clinical Trial registry and OneCare and OneCare Connect coverage for routine costs. A Clinical Trial shall have the following ~~desirable~~ characteristics:

1. The principal purpose of the Clinical Trial is to test whether the intervention potentially improves the Member's health outcomes;

2. The Clinical Trial is well-supported by available scientific and medical information, or is intended to clarify, or establish, the health outcomes of interventions already in common clinical use;

3. The Clinical Trial does not unjustifiably duplicate existing studies;

4. The Clinical Trial design is appropriate to answer the research question being asked in the Clinical Trial;

5. The Clinical Trial is sponsored by a credible organization or individual capable of executing the proposed Clinical Trial successfully;

6. The Clinical Trial is in compliance with Federal regulations relating to the protection of human subjects; and

7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.

~~Routine costs in Clinical Trials include:~~

~~1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);~~

~~2.~~1. ~~Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);~~

~~3.~~1. ~~The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and~~

~~4.~~1. ~~Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.~~

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D. Routine costs exclude the following:

1. The Investigational Service or item;

2.1. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

3.1. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.

I. Payment will not be authorized for Investigational Services that do not meet the above criteria set out in this Policy, or for associated inpatient care, when a Member needs to be in the hospital primarily because she or he is receiving such non-approved Investigational Services. For non-covered items and services, only the treatment of complications arising from the delivery of the non-covered item or service, and unrelated reasonable and necessary care is a covered benefit.

## III. PROCEDURE

A. All requests for Investigational Services or Experimental Services, including Clinical Trials, must be reviewed and authorized by the CMO, or his or her Designee, prior to services being provided to Members.

1. For WCM Members, requests shall be evaluated for Medical Necessity in accordance with California Children's Services (CCS) guidelines as provided in CCS Numbered Letters.

2. In addition, for WCM Members, CalOptima shall authorize Investigational Services or Experimental Services in accordance with GG.1508: Authorization and Processing of Referrals or CCS Numbered Letters, whichever is least restrictive and as applicable.

B. Determination that a service is Experimental or Investigational is based on:

1. Relevant Federal regulations or guidance, such as those contained in Title 42, CFR, Chapter IV, and Title 21, CFR, Chapter I, Food and Drug Administration (FDA) 510k approvals, and certain other categories of FDA approval for limited use or continuing research, do not represent full and unrestricted FDA acceptance and would still be considered investigational. Further, devices or therapies which are fully FDA approved for some indications but are being used for indications other than those for which there is an FDA approval may also be deemed investigational;

2. Verification that the Clinical Trial meets the criteria for being registered with the Medicare clinical trials registry;

3. Consultation with provider organizations, academic and professional specialists pertinent to the specific medical service; and

4. Current medical literature in the United States.

C. Routine costs in Clinical Trials include:

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1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);

2. Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);

3. The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

4. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

D. Routine costs exclude the following:

1. The Investigational Service or item;

2. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.

E. A Member may appeal a CalOptima or Health Network decision to a requested service in accordance with CalOptima policies GG.1510: Appeal Process, MA.9003: Standard Appeal, and CMC.9003: Standard Appeal.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy MA.9003: Standard Appeal
~~E.~~F. CalOptima Policy CMC.9003: Standard Appeal
~~F.~~G. CalOptima Policy GG.1125: Cancer Clinical Trials
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~G.~~I. CalOptima Policy GG.1510: Appeal Process ~~CalOptima Policy MA.9003: Standard Appeal~~
~~H.~~J. Centers for Medicare & Medicaid Services, National Coverage Determination for Routine Costs in Clinical Trials, July 9, 2007
K. DHCS CCS Numbered Letter (N.L.) 05-1020: California Children's Services Program and Genetically Handicapped Persons Program Policy on Coverage of Experimental and Investigational Services

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~~I.~~L. Final National Coverage Decision-Clinical Trials, Social Security Act, Section 1862 (a)(1)(E)
~~J.~~M. Medicare Managed Care Manual, Chapter 4, Section 10.7.2
~~K.~~N. Medicare Benefit Policy Manual, Chapter 14, Section 20
~~L.~~O. Medicare Approved Clinical Trials/Clinical Research Studies List
~~M.~~P. Title 21, Code of Federal Regulations, Chapter I
~~N.~~Q. Title 22, California Code of Regulations, §§51056.1, 51303 (g) and (h)
~~O.~~R. Title 42, Code of Federal Regulations, Chapter IV
~~P.~~S. Title 42, United States Code, §300gg-8
~~Q.~~T. Welfare and Institutions Code, §14132.98

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

None to Date

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 02/01/2002 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |
| Revised | 05/01/2007 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |
| Reviewed | 09/01/2014 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |
| Effective | 08/01/2005 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 07/01/2008 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 11/01/2015 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Retired | 12/22/2015 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 10/01/2016 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 08/01/2017 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/01/2018 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 06/01/2020 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | TBD | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |

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1
# IX. GLOSSARY
2

| Term | Definition |
| --- | --- |
| Activities of Daily Living (ADL) | Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing. |
| Category A Experimental Device | A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective. |
| Category B Non-Experimental/Investigational Device | A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration FDA premarket approval or clearance for that device type. |
| Clinical Trials | Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics:<br><br>1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes;<br>2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;<br>3. The Clinical Trial does not unjustifiably duplicate existing studies;<br>4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial;<br>5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial;<br>6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and<br>7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity. |
| 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. |
| Durable Medical Equipment (DME) | Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home.<br><br>DME:~~Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient that:~~<br><br>1. Can withstand repeated use.<br>2. Is used to serve a medical purpose.<br>3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.<br>4. Is appropriate for use in or out of the patient's home. |



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| Term | Definition |
| --- | --- |
| Experimental Services | Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans. |
| Investigational Services | Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in progress but testing is not complete (Phase III clinical trials are not yet completed and published), the efficacy and safety of such services in human subjects are not yet established, and the service is not generally accepted by the medical community in the United States or in widespread general medical usage in the United States. |
| Medically Necessary or Medical Necessity | Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.<br><br>For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.<br><br>OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.<br><br>OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5. |
| Member | ~~An Member~~ A beneficiary ~~of~~enrolled in a CalOptima program. |

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| Term | Definition |
|---|---|
| Prior Authorization | Medi-Cal: A formal process requiring a health care Provider to obtain advance approval to provide specific services or proceduresof Medically Necessary Covered Services, including the Medically Necessary and to what amount, duration, and scope of services, except in the case of an emergency.<br><br>OneCare &/ OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member. |

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| | |
|---|---|
| Policy: | GG.1102 |
| Title: | **Experimental and Investigational Service Coverage** |
| Department: | Medical Management |
| Section: | Utilization Management |
| *CEO Approval*: | |
| Effective Date: | 02/01/2002 |
| Revised Date: | TBD |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☒ OneCare Connect<br>☐ PACE<br>☐ Administration |

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1 **I. PURPOSE**
2
3 This policy defines the benefit coverage for Experimental and Investigational Services under the
4 CalOptima program.
5
6 **II. POLICY**
7
8 A. Experimental Services are not covered under the Department of Health Care Services (DHCS)
9 Medi-Cal program, Whole Child Model (WCM) program, or the Centers for Medicare & Medicaid
10 Services (CMS) Medicare or Duals Demonstration programs, except as specified in this Policy or
11 specifically authorized by law.
12
13 B. Coverage of Investigational Services in the Medi-Cal program
14
15 1. Investigational Services require Prior Authorization, and are covered when it is clearly
16 documented that all of the following apply:
17
18 a. The Member has a life threatening or seriously debilitating disease or medical condition;
19
20 b. There is a medically reasonable expectation that the Investigational Service will
21 significantly prolong the intended Member's life or will maintain or restore a range of
22 physical and social function suited to Activities of Daily Living (ADL);
23
24 c. Conventional therapy will not prevent progressive disability or premature death, nor
25 adequately treat the intended Member's condition;
26
27 d. The provider of the proposed service has a record of safety and success, which is equivalent
28 or superior to that of other providers of the Investigational Service;
29
30 e. The Investigational Service is the lowest cost item or service that meets the Member's
31 medical needs and is less costly than all conventional alternatives; and
32
33 f. The service is not being performed as a part of a research study protocol.
34
35 C. Coverage of Investigational Services in the OneCare and OneCare Connect programs
36

1. Category A and Category B Investigational Device Exemption (IDE) studies require Prior Authorization, and are covered when the following requirements are met:

   a. The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients;

   b. The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c. The study results are not anticipated to unjustifiably duplicate existing knowledge;

   d. The study design is methodologically appropriate, and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study;

   e. The study is sponsored by an organization or individual capable of successfully completing the study;

   f. The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in Title 21 of the Code of Federal Regulations (CFR), Parts 50, 56, and 812, and Title 45, CFR., Part 46;

   g. Where appropriate, the study is not designed to exclusively test toxicity, or disease pathophysiology, in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one (1) of the objectives may be exempt from this criterion, only if the disease or condition being studied is life threatening and the patient has no other viable treatment options;

   h. The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov;

   i. The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes, and that the release should be hastened if the study is terminated early; and

   j. The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.

D. CalOptima shall cover cancer Clinical Trials, in accordance with CalOptima Policy GG.1125: Cancer Clinical Trials.

E. Coverage for routine costs of qualifying Clinical Trials are covered upon approval by the Chief Medical Officer (CMO) or his or her Designee, unless the coverage of the service is otherwise defined as a non-covered service or item in Title 22, California Code of Regulations (C.C.R).

F. Coverage for Clinical Trials is restricted to participating hospitals and physicians in California, unless the protocol for the Clinical Trial is not provided for at a California hospital or by a California physician.

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G. For the Medi-Cal program, CalOptima or a Health Network shall provide coverage for routine costs for Investigational Services associated with a Clinical Trial, if the Clinical Trial meets the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within the benefit category of the Medicaid/Medicare program (e.g., Physician's service, Durable Medical Equipment (DME), diagnostic test) and are not statutorily excluded from coverage (e.g., cosmetic surgery).

2. The trial must not be designed exclusively to test toxicity, or disease pathophysiology. It must have therapeutic intent and be considered a Phase III Clinical Trial in the United States.

3. Trials of therapeutic interventions must enroll patients with a diagnosed disease, rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients, in order to have a proper control group.

H. The requirements in Section II.G. of this Policy are insufficient by themselves to qualify a Clinical Trial for the Medicare Clinical Trial registry and OneCare and OneCare Connect coverage for routine costs. A Clinical Trial shall have the following characteristics:

1. The principal purpose of the Clinical Trial is to test whether the intervention potentially improves the Member's health outcomes;

2. The Clinical Trial is well-supported by available scientific and medical information, or is intended to clarify, or establish, the health outcomes of interventions already in common clinical use;

3. The Clinical Trial does not unjustifiably duplicate existing studies;

4. The Clinical Trial design is appropriate to answer the research question being asked in the Clinical Trial;

5. The Clinical Trial is sponsored by a credible organization or individual capable of executing the proposed Clinical Trial successfully;

6. The Clinical Trial is in compliance with Federal regulations relating to the protection of human subjects; and

7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.

I. Payment will not be authorized for Investigational Services that do not meet the criteria set out in this Policy, or for associated inpatient care, when a Member needs to be in the hospital primarily because she or he is receiving such non-approved Investigational Services. For non-covered items and services, only the treatment of complications arising from the delivery of the non-covered item or service, and unrelated reasonable and necessary care is a covered benefit.

## III. PROCEDURE

A. All requests for Investigational Services or Experimental Services, including Clinical Trials, must be reviewed and authorized by the CMO or his or her Designee prior to services being provided to Members.

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1. For WCM Members, requests shall be evaluated for Medical Necessity in accordance with California Children's Services (CCS) guidelines as provided in CCS Numbered Letters.

2. In addition, for WCM Members, CalOptima shall authorize Investigational Services or Experimental Services in accordance with GG.1508: Authorization and Processing of Referrals or CCS Numbered Letters, whichever is least restrictive and as applicable.

B. Determination that a service is Experimental or Investigational is based on:

1. Relevant Federal regulations or guidance, such as those contained in Title 42, CFR, Chapter IV, and Title 21, CFR, Chapter I, Food and Drug Administration (FDA) 510k approvals, and certain other categories of FDA approval for limited use or continuing research, do not represent full and unrestricted FDA acceptance and would still be considered investigational. Further, devices or therapies which are fully FDA approved for some indications but are being used for indications other than those for which there is an FDA approval may also be deemed investigational;

2. Verification that the Clinical Trial meets the criteria for being registered with the Medicare clinical trials registry;

3. Consultation with provider organizations, academic and professional specialists pertinent to the specific medical service; and

4. Current medical literature in the United States.

C. Routine costs in Clinical Trials include:

1. Items or services that are typically provided absent a Clinical Trial (e.g., conventional care);

2. Items or services required solely for the provision of the Investigational Service or item (e.g., administration of a non-covered chemotherapeutic agent);

3. The clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

4. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

D. Routine costs exclude the following:

1. The Investigational Service or item;

2. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

4. Services not directly associated with health care, such as travel, housing, companion expenses, and other non-clinical expenses associated with the Clinical Trial.

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E. A Member may appeal a CalOptima or Health Network decision to a requested service in accordance with CalOptima policies GG.1510: Appeal Process, MA.9003: Standard Appeal, and CMC.9003: Standard Appeal.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy MA.9003: Standard Appeal
F. CalOptima Policy CMC.9003: Standard Appeal
G. CalOptima Policy GG.1125: Cancer Clinical Trials
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process
J. Centers for Medicare & Medicaid Services, National Coverage Determination for Routine Costs in Clinical Trials, July 9, 2007
K. DHCS CCS Numbered Letter (N.L.) 05-1020: California Children's Services Program and Genetically Handicapped Persons Program Policy on Coverage of Experimental and Investigational Services
L. Final National Coverage Decision-Clinical Trials, Social Security Act, Section 1862 (a)(1)(E)
M. Medicare Managed Care Manual, Chapter 4, Section 10.7.2
N. Medicare Benefit Policy Manual, Chapter 14, Section 20
O. Medicare Approved Clinical Trials/Clinical Research Studies List
P. Title 21, Code of Federal Regulations, Chapter I
Q. Title 22, California Code of Regulations, §§51056.1, 51303 (g) and (h)
R. Title 42, Code of Federal Regulations, Chapter IV
S. Title 42, United States Code, §300gg-8
T. Welfare and Institutions Code, §14132.98

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

None to Date

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 02/01/2002 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |
| Revised | 05/01/2007 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |
| Reviewed | 09/01/2014 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal |

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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 08/01/2005 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 07/01/2008 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 11/01/2015 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Retired | 12/22/2015 | MA.6008 | Experimental and Investigational Service | OneCare |
| Revised | 10/01/2016 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 08/01/2017 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/01/2018 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 06/01/2020 | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | TBD | GG.1102 | Experimental and Investigational Service Coverage | Medi-Cal<br>OneCare<br>OneCare Connect |

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1 **IX. GLOSSARY**
2

| Term | Definition |
|---|---|
| Activities of Daily Living (ADL) | Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing. |
| Category A Experimental Device | A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective. |
| Category B Non-Experimental/Investigational Device | A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration FDA premarket approval or clearance for that device type. |
| Clinical Trials | Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics:<br><br>1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes;<br>2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;<br>3. The Clinical Trial does not unjustifiably duplicate existing studies;<br>4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial;<br>5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial;<br>6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and<br>7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity. |
| 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. |
| Durable Medical Equipment (DME) | Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home.<br><br>DME:<br>1. Can withstand repeated use.<br>2. Is used to serve a medical purpose.<br>3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.<br>4. Is appropriate for use in or out of the patient's home. |
| Experimental Services | Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans. |

For 20210506 BOD Review Only

| Term | Definition |
|---|---|
| Investigational Services | Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in progress but testing is not complete (Phase III clinical trials are not yet completed and published), the efficacy and safety of such services in human subjects are not yet established, and the service is not generally accepted by the medical community in the United States or in widespread general medical usage in the United States. |
| Medically Necessary or Medical Necessity | Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.<br><br>For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.<br><br>OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.<br><br>OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5. |
| Member | A beneficiary enrolled in a CalOptima program. |

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| Term | Definition |
| --- | --- |
| Prior Authorization | Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration, and scope of services, except in the case of an emergency.<br><br>OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member. |

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For 20210506 BOD Review Only

Policy: GG.1301
Title: **Comprehensive Case Management Process**
Department: Medical Management
Section: Case Management

*CEO Approval:*

Effective Date: 01/01/07
Revised Date: TBD

Applicable to: ☒ Medi-Cal
☐ OneCare
☐ OneCare Connect
☐ PACE
☐ Administrative

For 20210506 BOD Review Only

## I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal program, by CalOptima~~,~~ or a Health Network.

## II. POLICY

A. 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.

B. The goal of Complex Case Management is to help a Member regain optimum health~~,~~ or improve functional capability, in the least restrictive setting and in a cost-effective manner.

1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.

~~C.~~ Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition~~,~~ functional capacity, determination of available benefits~~and,~~ resources, cultural and ~~development~~linguistic needs, Social Determinants of Health, and ~~implementation of a Case Management plan with performance goals, monitoring,~~barriers to care. This information is analyzed for meaning and ~~follow-up.~~

~~D. The Complex Case Management program description shall include the following:~~

~~1. Evidence used~~evaluated in a member-centric manner in order to develop ~~the program, including but not limited to:~~

~~a. Milliman~~and implement an Individual Care ~~Guidelines (MCG);~~

~~b. Institute for Clinical Improvement (ICSI);~~

~~c. Department of Health Care Services (DHCS) guidelines;~~

~~d. Centers for Medicare & Medicaid Services (CMS) guidelines;~~

~~e. Local and Intermediary Medicare Carrier coverage guidelines;~~

~~f. Centers of Excellence guidelines; and~~

~~g. Preventive health guidelines (e.g., U.S. Preventive Services Task Force).~~

~~2. Criteria used to identify Members who are eligible for the program;~~

~~3. Services offered to Members;~~

~~4. Defined program~~Plan (ICP) with prioritized Member goals~~;~~

~~E.~~C. ~~Case management services~~ that are ~~combined with the services of others involved in a Member's care.~~followed up on and monitored for progress.

~~F. Annually, CalOptima shall assess the characteristics and needs of its Member population and relevant subpopulations, which include, but are not limited to:~~

~~1. Children, adolescents, persons with disabilities, and persons with serious and persistent mental illness (SPMI): To assess the characteristics and needs of these subpopulations, CalOptima may use the following:~~

~~a. Race;~~

~~b. Ethnicity;~~

~~c. Language preference;~~

~~d. Member gender;~~

~~e. Member age;~~

~~f. Aid code category;~~

~~g. Severe diagnoses;~~

~~h. Co-morbid diagnoses;~~

~~i. Behavioral health diagnosis;~~

~~j. Inpatient admissions;~~

~~k. Emergency department utilization; and~~

~~l. Number of prescriptions.~~

~~G. The following data sources shall be utilized for the population assessment:~~

~~a. Information from the Department of Health Care Services (DHCS) (e.g., eligibility files);~~

~~b. Claims data; and~~

~~c. Encounter data;~~

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H.D. CalOptima shall review and update its Case Management processes and resources to address Member needs, if necessary.

E. CalOptima or a Health Network shall ensure the provision of Case Management for CalOptima Members eligible with the California Children's Services (CCS) Program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

F. CalOptima or a Health Network shall ensure the provision of care management and care coordination for Members enrolled in the Health Homes Program in accordance with CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

G. CalOptima or a Health Network shall ensure the provision of Case Management services for Members approved for Private Duty Nursing Services in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management.

## III. PROCEDURE

A. CalOptima and a Health Network shall identify Members for Complex Case Management utilizing the following data sources;:

1. Claims, or Encounterencounter data;

2. Hospital, or discharge data;

3. Pharmacy data;

4. Health information form;

5. Data collected through the utilization management (UM) process;

6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;

7. Data supplied by Member, or caregiver; and

8. Data supplied by Practitioners.

B. CalOptima, or a Health Network, shall assess and provide Complex Case Management, as appropriate, to the following Members:

1. A Member who is high-risk, defined as:

a. A Member who has a medically- complex condition, including the most frequently managed conditions, diseases,; or high

a.b. High risk groups, that may include, but isare not limited to;:

i. Spinal Injuries;

ii. Transplants;

iii. Cancer;

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iv. Serious Trauma;

v. AIDS;

vi. Multiple chronic illnesses; and

vii. Chronic illnesses that result in high utilization.

2. A Member who has a complex social situation that affects the medical management of the Member's care;

3. A Member who requires an extensive use of resources; or

4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

C. CalOptima, or a Health Network, may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management, but would benefit from case management support. Care Coordination Case Management shall include:

1. Assistance with access to care issues;

2. Health and disease-specific education;

3. Referral to resources; and

4. Coordination of care with all Providers.

D. A Member may be referred to Complex Case Management through:

1. ~~Disease~~ Medical Management program referral;

2. Discharge ~~Planner~~planner referral;

3. ~~Utilization Management (~~UM~~)~~ referral~~, if applicable;~~;

4. Member or caregiver referral;

5. Practitioner referral;

6. Community agency; and

7. Health Network referral.

8. CalOptima shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:

a. Member ~~,~~newsletter;

b. Provider communications, including but not limited to, the Provider newsletter; and

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c. Other materials or forums, as appropriate.

~~8.~~9. CalOptima or a Health Network~~,~~ may receive referrals by electronic transmission, telephone, or written correspondence.

E. The Complex Case Management ~~program~~process shall include, but not be limited to:

1. Standardized mechanisms to systematically identify a high-risk Member;

2. Access to Case Management by ensuring multiple avenues for referrals;

3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case Management programs and services offered by CalOptima~~,~~ or a Health Network;

4. Complex Case Management system;

5. Documented Case Management process;

6. Initial assessment;

7. Process for providing ongoing Case Management;

8. Coordination of care to ensure provision of all Medically Necessary services;

9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary services;

10. Coordination of carve-out services;

11. Coordination of PDN nursing in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management, if applicable;

~~11.~~12. Coordination of services, both within and outside CalOptima's Service Area;

~~12.~~13. Coordination of long term services and supports (LTSS);

~~13.~~14. Coordination of behavioral health services;

~~14.~~15. Process for evaluating satisfaction with the Case Management program;

~~15.~~16. Process for measuring the effectiveness of Case Management; and

~~16.~~17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

~~I. CalOptima and a Health Network shall utilize Case Management systems that support Complex Case Management, as follows:~~

~~1. Evidence based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;~~

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2. A documentation process that includes automated notation of the staff members identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up contact scheduled with the Member.

I. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2.1. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. How CalOptima, or the Health Network, works with a Member in the Case Management program.

J.I. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's, or Health Network's, Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2.1. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

J. Annually, CalOptima shall analyze the effectiveness of its Complex Case Management program by identifying three (3) measures. For each identified measure, CalOptima shall:

1. Identify a relevant process, or outcome;

2. Use a valid method that provides quantitative results;

3. Set a performance measure;

4. Clearly identify measure specifications;

5. Collect data and analyze results; and

6. Identify opportunities for improvement, if applicable.

K. Based on the measurement and analysis of Complex Case Management program effectiveness outcomes, CalOptima shall:

1. Implement at least one (1) intervention to improve performance, if applicable

2. Implement at least one (1) intervention to improve satisfaction, if applicable;

3. Re-measure to determine impact performance, if applicable; and

4. Re-measure to determine impact on satisfaction, if applicable.

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L. CalOptima shall monitor a Health Network's Case Management program, in accordance with this policy and CalOptima Policy GG.1619: Delegation Oversight.

M. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) Targeted Case Management (TCM) services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:

Children under age twenty-one (21).

b. Medically fragile individuals.

c.b. Individuals at risk of institutionalization.

d.b. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

e.b. Individuals with a communicable disease.

N. CalOptima and a Health Network may identify and refer a member for DHCS TCM services when the Member meets the appropriate criteria listed below:

a. Member is determined to be in need of case management services for non-medical needs.

b.a. CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.

c.a. CalOptima has determined that Member would benefit from TCM face-to-face case management.

d.a. CalOptima has concerns that the Member has an inadequate support system for medical care.

e.a. CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.

O. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima, or a Health Network.

P. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima, or a Health Network.

Q. For Members who have both a TCM case manager and a CalOptima, or Health Network, case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.

## III.I. PROCEDURE

F. Triage Process

1. Upon receipt of a referral for Case Management, CalOptima, or a Health Network, shall triage the referral for Case Management as follows:


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a. CalOptima~~,~~ or a Health Network~~,~~ shall triage an urgent referral within ~~twenty-four (24) hours~~one (1) business day after receipt of the referral.

b. CalOptima~~,~~ or a Health Network~~,~~ shall triage a standard referral within five (5) business days after receipt of the referral.

2. If, upon review of a referral for Care Coordination Case Management~~,~~ or Complex Case Management, CalOptima~~,~~ or a Health Network~~,~~ determines that a Member qualifies for Care Coordination Case Management~~,~~ or Complex Case Management, CalOptima~~,~~ or a Health Network~~,~~ shall:

a. Contact the Member to obtain consent for Care Coordination Case Management~~,~~ or Complex Case Management~~,~~ services within ~~twenty-four (24) hours~~one (1) business day for an urgent referral and within five (5) business days for a routine referral;

b. ~~Perform~~Complete an initial assessment for the Member~~-~~ within ~~five (5) business~~thirty (30) calendar days ~~after the Member consents to Care Coordination Case Management, or Complex Case Management services;~~ of identification; and

c. Develop an ~~Individual Care Plan (~~ICP~~)~~ within ~~ten (10) business~~thirty (30) calendar days ~~after the completion of the initial~~of assessment.

G. Initial Member Assessment

1. CalOptima~~,~~ or a Health Network~~,~~ shall conduct a Member's initial assessment and evaluation in the following manner:

a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family~~,~~ or caregiver;

b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

c. Review of Medical Records by a case manager, as needed;

d. Consultation with CalOptima's or Health Networks' staff, as needed; or

e. Consultation with a community agency, as needed.

2. CalOptima~~,~~ or a Health Network~~,~~ shall include the following in a Member's initial assessment and evaluation for Complex Case Management~~:~~. CalOptima or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (*e.g.*, life-planning in pediatric cases).

a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status~~, and information~~. Information on the event or diagnosis that led to the Member's eligibility for Case Management~~.~~, and current medications, including schedules and dosages.

b. Documentation of clinical history~~,~~ including:

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i. Dates;

ii. Disease ~~disease~~ onset~~, comorbidities, and key events, such as acute phases, inpatient stays, ~~;

iii. Past hospitalizations and major procedures, including surgery;

~~i.~~iv. Significant past illnesses and treatment history~~, and current and past medications, including schedules and dosages;~~; and

~~b. Capacity for carrying out activities of daily living (ADLs), such as eating, bathing, and mobility, and instrumental activities of daily living (IADLs), such as light housekeeping, shopping and laundry;~~

v. Relevant past medications related to the Member's condition.

vi. This factor does not require evaluation.

c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., "Member is fully independent with ADLs.").

~~c.~~d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions~~,~~ or substance use disorders~~;~~.

~~d.~~e. ~~Identification~~Assessment of ~~possible psychosocial issues~~Social Determinants of Health that may affect Members' ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment~~;~~ (as Social Determinants of Health are a combination of influences, assessment must include more than one (1) Social Determinant of Health).

~~e.~~f. Assessment of the Member's life planning activities, such as wills, living wills, or advance directives ~~and~~, health care powers of attorney~~.~~, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima~~,~~ or a Health Network~~,~~ shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities~~;~~.

~~f.~~g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs~~;~~.

~~g.~~h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member~~;~~.

~~h.~~i. ~~Caregiver~~Evaluation for adequacy of caregiver resources, such as family or other support person involvement ~~in~~ and role in decision making about the care plan ~~and address~~

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~~adequacy of~~. Documentation describes the resources~~;~~ in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.

~~i.~~j. Evaluation of available benefits, including the Member's eligibility and pertinent financial information regarding benefits. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:

i. Benefits covered by ~~the~~ CalOptima~~,~~, the Health ~~Networks~~Network, and by Providers ~~(i.e., Disease Management and Health Education);~~;

ii. Services carved-out by CalOptima and Health Networks; and

iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).

k. Evaluation of community resources, including assessments of potential eligibility for community resources that supplement CalOptima resources, such as community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan.

~~j.~~l. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

i. California Children's Services (CCS), as described in CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program;

ii. Genetically Handicapped Persons Program (GHPP);

iii. HIV/AIDS Waiver Program;

iv. Home and Community-Based Services (HCBS);

v. Local Educational Agency (LEA);

vi. Regional Center of Orange County (RCOC~~);~~) ;

vii. In-Home Operations;

viii. Specialty Mental Health Services, as described in CalOptima Policy GG.1103: Specialty Mental Health Services;

ix. OCHCA Tuberculosis Program (Direct Observation Therapy); and

x. Long Term Services and Supports, including:

a) Community-Based Adult Services (CBAS);

b) In-Home Support Services (IHSS); and

c) Multipurpose Senior Services Program (MSSP~~);~~).

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~~3. Evaluation of community resources includes assessments of potential eligibility for providers of benefits supplementing those for which CalOptima has been contracted, such as employee assistance programs (EAP), palliative care programs, wellness organizations, and other national and community resources.~~

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima and a Health Network shall include the following elements in a Member's ICP:

   a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, ~~and includes~~including the following:

      i. Timeframe for re-evaluation;

      ii. Resources to be utilized, including the appropriate level of care;

      iii. Planning for continuity of care, including transition of care and transfers between settings;

      iv. Collaborative approaches to be used, including family participation; and

      v. Evaluating Member's personal preferences.

   b. Identification of barriers to meeting goals, or compliance with ICP:

      i. Barrier analysis shall include issues such as language, or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation, financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.

      ii. Documentation of assessment for barriers, even if none identified.

   c. Coordination of carved out services and referrals to appropriate community resources and agencies.

   d. Facilitation of Member referrals to appropriate resources, and a follow-up process to determine whether Members act on referrals, including referrals to external resources.

   e. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a ~~Disease~~Medical Management program, follow-up after referral to a health resource, and education self-management support.

      i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.

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ii. Documentation of the next scheduled Member contact and contact method.

f. Development and communication (e.g., orally or written) of a ~~Member's~~ self-management plan ~~of activities~~that is acknowledged and agreed to by the Member~~.~~ Self-management plans are ~~designed to shift the focus in patient care from~~actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members ~~receiving care from a Practitioner, or a care team, to Members providing care for themselves, where appropriate.~~or their caregivers. Member self-management plan of activities includes, but is not limited to:

   i. Maintaining a prescribed diet;

   ii. Charting daily readings (e.g., weight, blood sugar); or

   iii. Changing a wound dressing, as directed.

g. ~~A process to assess~~Assessment of progress towards meeting Case Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed.

h. Planning for continuity~~,~~ or transition~~,~~ of care when benefit coverage ends. CalOptima~~,~~ or a Health Network~~,~~ shall:

   i. Identify transitioning Members who are receiving approved services, but whose benefit coverage will end while still needing Medically Necessary care;

   ii. Identify available community resources and alternative care; and

   iii. Notify and educate transitioning Members regarding alternative care and community resources.

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.

4. CalOptima~~,~~ or a Health Network~~,~~ shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.

5. CalOptima and a Health Network shall terminate Complex Case Management for a Member when the Member:

   a. Achieves ICP goals;

   b. Becomes ineligible for Case Management; or

   c. Declines Case Management.

I. Targeted Case Management (TCM)

1. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:

   a. Children under age twenty-one (21).

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b. Medically fragile individuals.

c. Individuals at risk of institutionalization.

d. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

e. Individuals with a communicable disease.

2. CalOptima and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:

a. Member is determined to be in need of case management services for non-medical needs.

b. CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.

c. CalOptima has determined that Member would benefit from TCM face-to-face case management.

d. CalOptima has concerns that the Member has an inadequate support system for medical care.

e. CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.

3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima or a Health Network.

4. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima or a Health Network.

5. For Members who have both a TCM case manager and a CalOptima or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.

J. CalOptima and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

1. MCG evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;

2. A documentation process that includes automated notation of the staff members' identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

K. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

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1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. Information regarding how CalOptima or the Health Network works with a Member in the Case Management program.

L. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's~~,~~ or the Health Network's~~,~~ Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

~~K.~~M. CalOptima shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Policy GG.1619: Delegation Oversight.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCES

~~A. American Accreditation HealthCare Commission/URAC: Case Management Standards~~
~~B.~~A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
~~C.~~B. CalOptima Contract for Health Care Services
~~A.~~ Coordination and Provision of Public Health Care Services Contract~~CalOptima Policy AA.1000: Glossary of Terms~~
C.
D. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
E. CalOptima Policy GG.1103: Specialty Mental Health Services
F. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
G. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
H. CalOptima Policy GG.1352: Private Duty Nursing Care Management
~~F.~~I. CalOptima Policy GG.1619: Delegation Oversight
~~G.~~J. Case Management Society of America (CMSA): Standards of Practice for Case Management
~~B. Coordination and Provision of Public Health Care Services Contract, Amendment I~~
~~H.~~K. National Committee for Quality Assurance (NCQA) ~~2017 QI~~2021 PHM 5: Complex Case Management
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children's Service Whole Child Model Program
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
~~I.~~O. Title 22, California Code of Regulations (C.C.R.), §-51185
~~C. Welfare and Institutions Code, § 14132.44~~

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3 **VI. REGULATORY AGENCY APPROVALS**
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| Date | Regulatory Agency |
|---|---|
| 09/09/2015 | Department of Health Care Services (DHCS) |
| 01/20/2016 | Department of Health Care Services (DHCS) |

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6 **VII. BOARD ACTION(S)**
7

| Date | Meeting |
|---|---|
| 06/04/2009 | Regular Meeting of the CalOptima Board of Directors |

8
9 **VIII. REVISION HISTORY**
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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/2007 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2010 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 08/01/2011 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2013 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2014 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 04/01/2015 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 11/01/2015 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 10/01/2016 | GG.1301 | Comprehensive Case Management Process | Medi-Cal |
| Revised | 07/01/2017 | GG.1301 | Comprehensive Case Management Process | Medi-Cal |
| Revised | TBD | GG.1301 | Comprehensive Case Management Process | Medi-Cal |

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1 **IX. GLOSSARY**
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| Term | Definition |
|---|---|
| Authorized Representative | Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. |
| CalOptimaCalifornia Children's Services (CCS) | For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9. |
| Case Management | A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. |
| Complex Case Management | A programThe systematic coordination and assessment of coordinated care and services for membersprovided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. |
| Complex Case Management Eligible Member | Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to:<br><br>1. Spinal Injuries;<br>2. Transplants;<br>3. Cancer;<br>4. Serious trauma;<br>5. AIDS;<br>6. Multiple chronic illnesses; or<br>7. Chronic illnesses that result in high utilization.<br><br>Or Member with a Medical Conditionmedical condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources. |
| Health Homes Program (HHP) | All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Individual Care Plan (ICP) | A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices. |

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| Term | Definition |
|---|---|
| Medical Management Program | Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff. |
| Medically Necessary or Medical Necessity | Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.<br><br>For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. ~~Reasonable and necessary servicesCovered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. , achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members receiving MLTSS, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services.~~<br><br>~~When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).~~ |
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Primary Care Practitioner/Physician (PCP) | A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic. |

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Back to Item

Back to Agenda

| Term | Definition |
|---|---|
| Private Duty Nursing (PDN) | Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse. |
| Service Area | The ~~geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a~~ county or counties that CalOptima is approved to operate in under the terms of the DHCS contract. |
| Social Determinants of Health | Economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals. |
| Targeted Case Management | ~~Specialized case management services for~~Services which assist Medi-Cal ~~eligible individuals in a defined~~Members within specified target ~~population~~groups to gain access to needed medical, social, educational~~,~~ and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors. |
| Whole-Child Model (WCM) | An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. |

1

For 20210506 BOD Review Only

Policy: GG.1301
Title: **Comprehensive Case Management Process**
Department: Medical Management
Section: Case Management

*CEO Approval:*

Effective Date: 01/01/07
Revised Date: TBD

Applicable to:
☒ Medi-Cal
☐ OneCare
☐ OneCare Connect
☐ PACE
☐ Administrative

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1 **I. PURPOSE**
2
3 This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal
4 program, by CalOptima or a Health Network.
5
6 **II. POLICY**
7
8 A. Complex Case Management is the coordination of care and services provided to a Member who has
9 experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs
10 assistance in facilitating the appropriate delivery of care and services.
11
12 B. The goal of Complex Case Management is to help a Member regain optimum health or improve
13 functional capability, in the least restrictive setting and in a cost-effective manner.
14
15 1. Complex Case Management is considered an opt-out program; all eligible Members have the
16 right to participate or decline participation.
17
18 C. Complex Case Management involves a comprehensive initial assessment and evaluation of a
19 Member's condition, functional capacity, determination of available benefits, resources, cultural and
20 linguistic needs, Social Determinants of Health, and barriers to care. This information is analyzed
21 for meaning and evaluated in a member-centric manner in order to develop and implement an
22 Individual Care Plan (ICP) with prioritized Member goals that are followed up on and monitored for
23 progress.
24
25 D. CalOptima shall review and update its Case Management processes and resources to address
26 Member needs, if necessary.
27
28 E. CalOptima or a Health Network shall ensure the provision of Case Management for CalOptima
29 Members eligible with the California Children's Services (CCS) Program in accordance with
30 CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child
31 Model.
32
33 F. CalOptima or a Health Network shall ensure the provision of care management and care
34 coordination for Members enrolled in the Health Homes Program in accordance with CalOptima
35 Policy GG.1331: Health Homes Program (HHP) Services and Care Management.
36

G. CalOptima or a Health Network shall ensure the provision of Case Management services for Members approved for Private Duty Nursing Services in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management.

## III. PROCEDURE

A. CalOptima and a Health Network shall identify Members for Complex Case Management utilizing the following data sources:

1. Claims or encounter data;
2. Hospital or discharge data;
3. Pharmacy data;
4. Health information form;
5. Data collected through the utilization management (UM) process;
6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;
7. Data supplied by Member or caregiver; and
8. Data supplied by Practitioners.

B. CalOptima or a Health Network shall assess and provide Complex Case Management, as appropriate, to the following Members:

1. A Member who is high-risk, defined as:

   a. A Member who has a medically complex condition, including the most frequently managed conditions; or

   b. High risk groups, that may include, but are not limited to:

      i. Spinal Injuries;

      ii. Transplants;

      iii. Cancer;

      iv. Serious Trauma;

      v. AIDS;

      vi. Multiple chronic illnesses; and

      vii. Chronic illnesses that result in high utilization.

2. A Member who has a complex social situation that affects the medical management of the Member's care;

3. A Member who requires an extensive use of resources; or

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4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

C. CalOptima or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:

   1. Assistance with access to care issues;

   2. Health and disease-specific education;

   3. Referral to resources; and

   4. Coordination of care with all Providers.

D. A Member may be referred to Complex Case Management through:

   1. Medical Management program referral;

   2. Discharge planner referral;

   3. UM referral;

   4. Member or caregiver referral;

   5. Practitioner referral;

   6. Community agency; and

   7. Health Network referral.

   8. CalOptima shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:

      a. Member newsletter;

      b. Provider communications, including but not limited to, the Provider newsletter; and

      c. Other materials or forums, as appropriate.

   9. CalOptima or a Health Network may receive referrals by electronic transmission, telephone, or written correspondence.

E. The Complex Case Management process shall include, but not be limited to:

   1. Standardized mechanisms to systematically identify a high-risk Member;

   2. Access to Case Management by ensuring multiple avenues for referrals;

   3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case Management programs and services offered by CalOptima or a Health Network;

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4. Complex Case Management system;

5. Documented Case Management process;

6. Initial assessment;

7. Process for providing ongoing Case Management;

8. Coordination of care to ensure provision of all Medically Necessary services;

9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary services;

10. Coordination of carve-out services;

11. Coordination of PDN nursing in accordance with CalOptima Policy GG.1352: Private Duty Nursing Care Management, if applicable;

12. Coordination of services, both within and outside CalOptima's Service Area;

13. Coordination of long term services and supports (LTSS);

14. Coordination of behavioral health services;

15. Process for evaluating satisfaction with the Case Management program;

16. Process for measuring the effectiveness of Case Management; and

17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

F. Triage Process

1. Upon receipt of a referral for Case Management, CalOptima or a Health Network shall triage the referral for Case Management as follows:

   a. CalOptima or a Health Network shall triage an urgent referral within one (1) business day after receipt of the referral.

   b. CalOptima or a Health Network shall triage a standard referral within five (5) business days after receipt of the referral.

2. If, upon review of a referral for Care Coordination Case Management or Complex Case Management, CalOptima or a Health Network determines that a Member qualifies for Care Coordination Case Management or Complex Case Management, CalOptima or a Health Network shall:

   a. Contact the Member to obtain consent for Care Coordination Case Management or Complex Case Management services within one (1) business day for an urgent referral and within five (5) business days for a routine referral;

   b. Complete an initial assessment for the Member within thirty (30) calendar days of identification; and

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c. Develop an ICP within thirty (30) calendar days of assessment.

G. Initial Member Assessment

1. CalOptima or a Health Network shall conduct a Member's initial assessment and evaluation in the following manner:

   a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family or caregiver;

   b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

   c. Review of Medical Records by a case manager, as needed;

   d. Consultation with CalOptima's or Health Networks' staff, as needed; or

   e. Consultation with a community agency, as needed.

2. CalOptima or a Health Network shall include the following in a Member's initial assessment and evaluation for Complex Case Management. CalOptima or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (*e.g.,* life-planning in pediatric cases).

   a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status. Information on the event or diagnosis that led to the Member's eligibility for Case Management, and current medications, including schedules and dosages.

   b. Documentation of clinical history including:

      i. Dates;

      ii. Disease onset;

      iii. Past hospitalizations and major procedures, including surgery;

      iv. Significant past illnesses and treatment history; and

      v. Relevant past medications related to the Member's condition.

      vi. This factor does not require evaluation.

   c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., "Member is fully independent with ADLs.").

   d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions or substance use disorders.

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e. Assessment of Social Determinants of Health that may affect Members' ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment (as Social Determinants of Health are a combination of influences, assessment must include more than one (1) Social Determinant of Health).

f. Assessment of the Member's life planning activities, such as wills, living wills, or advance directives, health care powers of attorney, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima or a Health Network shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities.

g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member.

i. Evaluation for adequacy of caregiver resources, such as family or other support person involvement-and role in decision making about the care plan. Documentation describes the resources in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.

j. Evaluation of available benefits, including the Member's eligibility and pertinent financial information regarding benefits. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:

   i. Benefits covered by CalOptima, the Health Network, and by Providers;

   ii. Services carved-out by CalOptima and Health Networks; and

   iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).

k. Evaluation of community resources, including assessments of potential eligibility for community resources that supplement CalOptima resources, such as community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan.

l. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

   i. California Children's Services (CCS), as described in CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program;

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ii. Genetically Handicapped Persons Program (GHPP);

iii. HIV/AIDS Waiver Program;

iv. Home and Community-Based Services (HCBS);

v. Local Educational Agency (LEA);

vi. Regional Center of Orange County (RCOC) ;

vii. In-Home Operations;

viii. Specialty Mental Health Services, as described in CalOptima Policy GG.1103: Specialty Mental Health Services;

ix. OCHCA Tuberculosis Program (Direct Observation Therapy); and

x. Long Term Services and Supports, including:

a) Community-Based Adult Services (CBAS);

b) In-Home Support Services (IHSS); and

c) Multipurpose Senior Services Program (MSSP).

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima and a Health Network shall include the following elements in a Member's ICP:

a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, including the following:

i. Timeframe for re-evaluation;

ii. Resources to be utilized, including the appropriate level of care;

iii. Planning for continuity of care, including transition of care and transfers between settings;

iv. Collaborative approaches to be used, including family participation; and

v. Evaluating Member's personal preferences.

b. Identification of barriers to meeting goals, or compliance with ICP:

i. Barrier analysis shall include issues such as language, or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation,

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financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.

ii. Documentation of assessment for barriers, even if none identified.

c. Coordination of carved out services and referrals to appropriate community resources and agencies.

d. Facilitation of Member referrals to appropriate resources, and a follow-up process to determine whether Members act on referrals, including referrals to external resources.

e. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a Medical Management program, follow-up after referral to a health resource, and education self-management support.

i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.

ii. Documentation of the next scheduled Member contact and contact method.

f. Development and communication (e.g., orally or written) of a self-management plan that is acknowledged and agreed to by the Member. Self-management plans are actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members or their caregivers. Member self-management plan of activities includes, but is not limited to:

i. Maintaining a prescribed diet;

ii. Charting daily readings (e.g., weight, blood sugar); or

iii. Changing a wound dressing, as directed.

g. Assessment of progress towards meeting Case Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed.

h. Planning for continuity or transition of care when benefit coverage ends. CalOptima or a Health Network shall:

i. Identify transitioning Members who are receiving approved services, but whose benefit coverage will end while still needing Medically Necessary care;

ii. Identify available community resources and alternative care; and

iii. Notify and educate transitioning Members regarding alternative care and community resources.

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.

4. CalOptima or a Health Network shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.

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5. CalOptima and a Health Network shall terminate Complex Case Management for a Member when the Member:

   a. Achieves ICP goals;

   b. Becomes ineligible for Case Management; or

   c. Declines Case Management.

I. Targeted Case Management (TCM)

1. CalOptima and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Case Management assessment, and meets criteria outlined below:

   a. Children under age twenty-one (21).

   b. Medically fragile individuals.

   c. Individuals at risk of institutionalization.

   d. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

   e. Individuals with a communicable disease.

2. CalOptima and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:

   a. Member is determined to be in need of case management services for non-medical needs.

   b. CalOptima has determined that the Member has demonstrated an on-going inability to access CalOptima services.

   c. CalOptima has determined that Member would benefit from TCM face-to-face case management.

   d. CalOptima has concerns that the Member has an inadequate support system for medical care.

   e. CalOptima has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima care plan.

3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima or a Health Network.

4. CalOptima shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima or a Health Network.

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5. For Members who have both a TCM case manager and a CalOptima or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, as needed.

J. CalOptima and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

1. MCG evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;

2. A documentation process that includes automated notation of the staff members' identification, date and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

K. CalOptima and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

3. Information regarding how CalOptima or the Health Network works with a Member in the Case Management program.

L. On an annual basis, CalOptima shall evaluate Member satisfaction with CalOptima's or the Health Network's Case Management program. CalOptima shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;

2. Analyzing Member complaints and inquiries; and

3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

M. CalOptima shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Policy GG.1619: Delegation Oversight.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Contract for Health Care Services
C. Coordination and Provision of Public Health Care Services Contract
D. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
E. CalOptima Policy GG.1103: Specialty Mental Health Services

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F. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
G. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management
H. CalOptima Policy GG.1352: Private Duty Nursing Care Management
I. CalOptima Policy GG.1619: Delegation Oversight
J. Case Management Society of America (CMSA): Standards of Practice for Case Management
K. National Committee for Quality Assurance (NCQA) 2021 PHM 5: Complex Case Management
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children's Service Whole Child Model Program
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
O. Title 22, California Code of Regulations (C.C.R.), §51185

## VI. REGULATORY AGENCY APPROVALS

| Date | Regulatory Agency |
|---|---|
| 09/09/2015 | Department of Health Care Services (DHCS) |
| 01/20/2016 | Department of Health Care Services (DHCS) |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 06/04/2009 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/2007 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2010 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 08/01/2011 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2013 | GG.1301 | Case Management Process | Medi-Cal |
| Revised | 01/01/2014 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 04/01/2015 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 11/01/2015 | GG.1301 | Complex Case Management Process | Medi-Cal |
| Revised | 10/01/2016 | GG.1301 | Comprehensive Case Management Process | Medi-Cal |
| Revised | 07/01/2017 | GG.1301 | Comprehensive Case Management Process | Medi-Cal |
| Revised | TBD | GG.1301 | Comprehensive Case Management Process | Medi-Cal |

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1 **IX. GLOSSARY**
2

| Term | Definition |
|---|---|
| Authorized Representative | A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. |
| California Children's Services (CCS) | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9. |
| Case Management | A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. |
| Complex Case Management | The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. |
| Complex Case Management Eligible Member | Members who are at high-risk, defined as having medically complex conditions that may include the following but is not limited to:<br><br>1. Spinal Injuries;<br>2. Transplants;<br>3. Cancer;<br>4. Serious trauma;<br>5. AIDS;<br>6. Multiple chronic illnesses; or<br>7. Chronic illnesses that result in high utilization.<br><br>Or Member with a medical condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources. |
| Health Homes Program (HHP) | All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Individual Care Plan (ICP) | A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices. |
| Medical Management Program | Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff. |

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| Primary Care Practitioner/Physician (PCP) | A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic. |
| Private Duty Nursing (PDN) | Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN), under the direction of a Member's physician, for a Member who requires more individual and continuous care than what would be available from a visiting nurse. |
| Service Area | The county or counties that CalOptima is approved to operate in under the terms of the DHCS contract. |
| Social Determinants of Health | Economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals. |
| Targeted Case Management | Services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors. |

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| Term | Definition |
|---|---|
| Whole-Child Model (WCM) | An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. |

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| | |
|---|---|
| Policy: | GG.1313 |
| Title: | **Coordination of Care for Transplant Members** |
| Department: | Medical Management |
| Section: | Case Management |
| *CEO Approval:* | */s/* |
| Effective Date: | 01/01/2000 |
| Revised Date: | TBD |
| Applicable to: | ☒ Medi-Cal<br>☐ OneCare<br>☐ OneCare Connect<br>☐ PACE<br>☐ Administrative |

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## I. PURPOSE

This policy defines the Case Management guidelines for coordination of care by CalOptima and a Health Network for a Member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ Transplant.

## II. POLICY

A. A Transplant shall be a Covered Service in accordance with CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

B. If a Health Network Member, including a Whole Child Model (WCM) Member, except a Kaiser Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows:

1. Referral and Evaluation phase:

   a. CalOptima shall provide Case Management for Covered Services directly related to the Transplant referral and evaluation.

   b. The Health Network shall provide Case Management for all other Covered Services including, but not limited to, the management of ~~ventricular assistive device~~Ventricular Assistive Device (VAD) procedures, ~~dialysis~~Dialysis, and ~~transjugular intrahepatic portosystemic shunt~~Transjugular Intrahepatic Portosystemic Shunt (TIPS) procedures.

2. For Listed, Transplant, and post-Transplant phases (up to three-hundred-sixty-five (365) calendar days post-~~transplant~~Transplant): CalOptima shall provide Case Management for all Covered Services.

C. CalOptima shall be responsible for providing Case Management to a Member who is enrolled in CalOptima Direct, including a WCM Member, and who is identified as a candidate for BMT or a Solid Organ Transplant.

D. Kaiser Foundation Health Plan, Incorporated (Kaiser) shall provide Case Management to a Kaiser Member who is a potential candidate for BMT or a Solid Organ Transplant and shall assist such

Kaiser Member with coordination of care ~~through~~throughout the Transplant process in accordance with the provisions of Section III.B of this policy.

E. CalOptima shall direct a CalOptima Direct Member or a Health Network Member, except a Kaiser Member, to the appropriate Department of Health Care Services (DHCS~~-~~)-approved Transplant Center, or to a Designated Special Care Center for Members with a California Children's Services (CCS)-Eligible Condition, as ~~needed~~applicable.

   1. Kaiser shall direct a Kaiser Member to the appropriate DHCS-approved Transplant Center, as needed~~.~~, or to a Designated Special Care Center for Members with a CCS-Eligible Condition, as applicable.

F. CalOptima shall provide ongoing education, collaboration, and oversight of Health Network case managers performing Case Management to a Member who is a candidate for BMT or a Solid Organ Transplant.

~~G. On or before December 31, 2018, a Member's Health Network and CalOptima shall refer a Member who is less than twenty-one (21) years of age and potentially eligible for a Transplant to California Children Services (CCS) for evaluation and authorization, in accordance with CalOptima Policy GG.1101: California Children's Services. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including transplant services.~~

## III. PROCEDURE

A. If a Health Network Member~~,~~ (except a Member enrolled in Kaiser) or CalOptima Direct Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows~~:~~:

   1. Referral Phase

      a. A Provider shall identify a Member as a potential candidate for BMT or a Solid Organ Transplant.

         i. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services ~~to~~from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals, and shall request authorization from the Member's Health Network for all other Covered Services in accordance with requirements set forth by the Health Network.

         ii. If the Member is enrolled in CalOptima Direct, the Provider shall request authorization for Covered Services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

      b. If a Health Network receives a request for authorization for a Transplant evaluation:

         i. The Health Network shall notify the Provider to request authorization from CalOptima and shall forward the request to CalOptima's ~~Case~~Utilization Management Department within one (1) working day after receipt.

         ii. The Health Network case manager shall notify the CalOptima case manager that the Member is a potential candidate for BMT or a Solid Organ Transplant by sending an

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Adult Transplant Notification and Request Form by facsimile, to CalOptima's Case Management Department within:

1) Five (5) working days after identifying the Member for Routine Care; and

2) Twenty-four (24) hours or the next working day after identifying the Member for Urgent Care.

iii. The Health Network case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iv. The Health Network case manager shall complete an initial assessment and create a care plan appropriate for the Member. The Health Network case manager shall update the assessment and care plan as the Member's status changes.

c. If the Member is enrolled in CalOptima Direct, or if CalOptima receives a request for authorization for a Transplant Evaluation for a Health Network Member:

i. The CalOptima Case Management Department shall open a case for ~~case management~~Case Management.

ii. The CalOptima case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iii. After opening a Transplant case to Case Management, the CalOptima case manager shall complete an initial assessment and create a care plan appropriate for the Member. The CalOptima case manager shall update the assessment and care plan as the Member's status changes.

iv. The CalOptima case manager shall mail a Transplant information packet to the Member within five (5) working days after receipt of written notification. The case manager shall contact the Member by telephone within ten (10) working days after mailing the packet to ensure that the Member received the information and to ~~identify~~address any questions or concerns that the Member may have.

v. The CalOptima case manager will coordinate with a DHCS-approved Transplant Center or a Designated Special Care Center for Members with a CCS-Eligible Condition, to facilitate completion of the referral.

2. Evaluation Phase

a. A DHCS-approved Transplant Center or a Designated Special Care Center shall request authorization for ~~transplant~~Transplant evaluation from CalOptima. If the Health Network receives the authorization for a ~~transplant~~Transplant evaluation from the DHCS-approved

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Transplant Center, or at a Designated Special Care Center the Health Network shall forward the request to the CalOptima Case Management Department within one (1) working day.

b. The CalOptima ~~Case~~Utilization Management Department shall provide authorization for a Transplant evaluation at the DHCS-approved Transplant Center or at the Designated Special Care Center, as applicable, within the following timeframes:

i. Five (5) working days after receipt of a request and information needed to make a decision regarding Medical Necessity for Routine Care; and

ii. ~~Twenty-four (24~~Seventy-two (72) hours ~~or the next working day after opening the case~~ for Urgent Care.

c. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for BMT or a Solid Organ Transplant.

The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's ~~Case~~case, to identify any issues that may prevent the Member from completing the evaluation~~.~~ and to assist

d. ~~If~~ the ~~DHCS-approved Transplant Center is unable to complete~~Member with coordinating the evaluation ~~within the ninety (90) calendar days after the Member's first evaluation appointment, the DHCS-approved Transplant Center shall notify and coordinate with the CalOptima case manager.~~.

e. Upon completion of a Member's evaluation, and approval for listing, the DHCS-approved Transplant Center or a Designated Special Care Center shall submit a Transplant Packet and request for authorization for ~~transplant~~Transplant to CalOptima for review within the following timeframes:

i. Five (5) working days after receipt of a request for Routine Care; and

ii. Twenty-four (24) hours or the next working day after receipt of a request for Urgent Care.

f. CalOptima shall notify the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and the Member's Health Network of the outcome of CalOptima's Chief Medical Officer's (CMO) or Designee's review, including CalOptima's approval or denial of the Transplant within the timeframes set forth in the CalOptima Utilization Management (UM) Program.

g. The CalOptima case manager shall verify Member eligibility on a monthly basis and shall notify the Member's Health Network case manager and the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, of any changes in the Member's eligibility.

3. Listing Phase

a. The Member's Health Network shall immediately notify CalOptima upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for BMT.

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b. Upon notice from a DHCS-approved Transplant Center or a Designated Special Care Center, for a Health Network that a Member is listed for a Solid Organ Transplant or is approved for BMT, the CalOptima case manager shall notify the CalOptima Customer Service Department. The CalOptima Customer Service Department shall transition the Member to CalOptima Direct, effective the first (1st) calendar day of the month after the date CalOptima receives the above notice in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

c. The CalOptima case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and authorize Covered Services for the Member, as appropriate.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to coordinate a Member's care and identify any issues which may lead to the Member's listing being placed in Status 7 or to removal from Transplant listing.

4. Transplant Phase and Post-Transplant Phase

a. The CalOptima case manager shall follow the Member's progress during the hospital admission for the Transplant and coordinate with the facility case manager to ensure that all discharge needs are met.

b. Upon the Member's discharge, the CalOptima case manager shall provide ongoing communication with a Member as the severity and complexity of the case requires, but not less than on a monthly basis, to ~~identify~~address any issues and to assist in coordinating follow-up care.

c. CalOptima shall provide ~~case management~~Case Management for three-hundred-sixty-five (365) calendar days after the Transplant.

d. At three-hundred-sixty-five (365) calendar days post~~-transplant~~-Transplant, the CalOptima case manager shall discuss any Member issues with the Member, including selection of a Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection, and shall transition the Member's care to the Member's selected Health Network if the Member wishes to transition to a Health Network.

e. The CalOptima case manager shall close the Member's case upon:

i. The Member's transition to a Health Network; or

ii. When goals are met, or the case meets closure criteria for CalOptima Direct Members.

B. If Kaiser identifies a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant, Kaiser shall provide Case Management of the Member as follows:

1. Referral Phase

a. Kaiser is responsible for identifying a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant.

b. The Kaiser case manager shall notify the CalOptima case manager, by submitting a Notification of Transplant Member form, that the Member is a potential Transplant

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candidate within five (5) working days after the Member is identified and shall open the case to ~~case management~~Case Management.

c. After opening a Transplant case to Case Management, the Kaiser case manager shall:

i. Place an introductory call to the ~~member~~Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

ii. Complete an initial assessment and create a care plan appropriate for the Member;

iii. Update the assessment and care plan as the Member's status changes; and

iv. Notify the CalOptima case manager, in writing, of any significant changes in the Member's status.

d. The CalOptima case manager shall update the medical management system and complete the ~~transplant~~Transplant reporting script for Kaiser ~~transplants~~Transplants on a monthly basis.

e. The Kaiser case manager shall mail a Transplant information packet to the Member within five (5) working days after notification. The case manager shall place a follow-up call to the Member ten (10) days after mailing the packet to ensure that the Member received the packet and to ~~identify~~address any questions or concerns that the Member may have.

2. Evaluation Phase

a. Kaiser shall direct a Kaiser Member identified as a potential candidate for BMT or a Solid Organ Transplant to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, for evaluation.

b. Kaiser shall provide authorization to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, in order to ensure that the DHCS-approved Transplant Center or the Designated Special Care Center completes the Transplant evaluation.

~~i. IfIf Kaiser receives notice from a DHCS-approved Transplant Center that the DHCS-approved Transplant Center is unable to complete the Transplant evaluation within ninety (90) calendar days after the Member's first (1st) appointment at the DHCS-approved Transplant Center, Kaiser shall submit a request for an extension to CalOptima.~~

~~1) Kaiser shall submit the request for an extension to CalOptima, by facsimile, no later than five (5) calendar days prior to the expiration of the required timeframe or a previously granted extension.~~

~~2) CalOptima shall review the extension request and shall notify Kaiser of its determination within five (5) working days after receipt of such request.~~

~~3) If CalOptima approves a request for extension, such extension shall be valid for thirty (30) calendar days. CalOptima may approve up to three (3) extension requests per evaluation.~~

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~~4) CalOptima's CMO or Designee shall have final authority over extension determinations.~~

~~ii. If Kaiser fails to complete a Transplant Evaluation within ninety (90) calendar days after the Member's first (1st) appointment at the DHCS-approved Transplant Center or within the timeframes granted by extension, CalOptima may:~~

~~1) Place the case on Administrative Hold until an evaluation is completed; or~~

~~2) Impose Sanctions on Kaiser for non-compliance in accordance with CalOptima Policy HH.2002: Sanctions.~~

c. ~~If a DHCS-approved Transplant~~ a DHCS-approved Transplant Center or a Designated Special Care Center places a Kaiser Member on Transplant Center Hold, the Kaiser case manager shall contact the CalOptima case manager with the Member's status including reason for the Transplant Center Hold and Kaiser's plan of action to resolve the issue. The CalOptima case manager shall document this information in the Transplant database.

d. Upon completion of the Transplant evaluation, Kaiser shall review the Transplant Packet and approve or deny the ~~transplant~~Transplant in pursuant to timeframes set forth in the CalOptima UM Program.

~~e. Kaiser shall submit to CalOptima's CMO or Designee the transplant packet and outcome of its review, indicating if the requested Transplant is approved or denied, and the reasons for such determination:~~

~~i. Within one (1) working day after Kaiser renders such determination, or~~

~~ii. On the same day of receipt of a request for Urgent Care.~~

~~f. CalOptima's CMO or Designee shall review Kaiser's UM decision. If CalOptima's CMO or Designee does not agree with Kaiser's UM decision:~~

~~i. CalOptima shall notify Kaiser of the outcome of its review, indicating if the Transplant is approved or denied, within the timeframes set forth in the CalOptima UM Program.~~

~~If CalOptima's CMO or Designee does not agree with Kaiser UM decision, CalOptima shall notify Kaiser, in writing, of its decision to overrule Kaiser's UM decision within one (1) working day after making such determination.~~

~~g.~~f. The Kaiser case manager shall follow-up with the Member as the severity and complexity of the case requires, but not less than on a monthly basis, to ~~identify~~address any issues that may prevent the Member from completing the Transplant evaluation.

3. Listing Phase

a. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center for a Member who is in the listed phase or who is in Status 7 and shall authorize Covered Services related to the Transplant and the medical management of the Member.

4. Transplant Phase and Post-Transplant Phase

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a. The Kaiser case manager shall follow a Member's progress during the Member's hospital admission for the Transplant, coordinate with the DHCS-approved Transplant Center's case manager or the Designated Special Care Center's case manager, to ensure that all discharge needs are met, and notify CalOptima of the Member's Transplant date within three (3) working days after the date of Transplant.

b. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or with the Designated Special Care Center and provide authorizations as needed for follow-up care.

c. The Kaiser case manager shall provide ongoing ~~case management~~Case Management of a Member as the complexity and severity of the case requires, but not less than once monthly, for three hundred sixty-five (365) calendar days after the Transplant.

d. The Kaiser case manager shall notify the CalOptima case manager, in writing, within five (5) working days after closing a case.

5. Kaiser shall submit reports to CalOptima in accordance with CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports.

## IV. ATTACHMENT(S)

A. Adult Transplant Notification and Request Form

## V. REFERENCE(S)

A. Contract for Health Care Provider Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
G. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy HH.2002Δ: Sanctions
K. Flow Chart: Coordination of Care for Transplant Members – CalOptima Direct and Health Networks

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency |
|---|---|
| 03/29/2016 | Department of Health Care Services (DHCS) |
| 10/09/2017 | Department of Health Care Services (DHCS) |

## VII. BOARD ACTION(S)

Not Applicable

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1 VIII. REVISION HISTORY

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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/2000 | GG.1313 | Coordination of Care for Members Eligible for Organ Transplants and Health Network Eligibility for Transplant Service Reimbursement | Medi-Cal |
| Revised | 11/01/2001 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 01/01/2006 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 03/01/2014 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 01/01/2016 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 09/01/2017 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 09/01/2018 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | TBD | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |

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## IX. GLOSSARY

| Term | Definition |
|---|---|
| Administrative Hold | A cease in reimbursement by CalOptima for Covered Services related to a Transplant evaluation to a Health Network pending resolution of administrative issues. CalOptima's Transplant Committee reviews all Administrative Hold cases on an individual basis. |
| Bone Marrow Transplant (BMT) | A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated ~~donor~~Donor (MUD) with human histocompatibility antigens (HL-A) that meet Department of Health Care Services (DHCS) standards. |
| California Children Services Program (CCS) | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9. |
| California Children Services (CCS) Eligible Conditions | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9. |
| CalOptima Direct | A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct. |
| Case Management | A systematic approach to coordination of care for a patient with special needs and or complex medical conditions that includes the elements of assessment, care planning, interventions monitoring, and documentation. |
| Covered Services | Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. |

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| Term | Definition |
|---|---|
| Designated Special Care Center | Centers that provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions. |
| Designee | A person selected or designated to carry out a duty or role. The assigned designeeDesignee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role. |
| Department of Health Care Services (DHCS) | The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs. |
| DHCS-approved Transplant Center | A facility that is approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplantsTransplants, a DHCS-approved Transplant Center is a facility that:<br><br>1. Is certified for, and participates in, the Medicare program; and<br>2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program. |
| Dialysis | A medical procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances. This is a procedure often performed on individuals with extremely poor kidney function. |
| Donor | An individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant. For a BMT, the Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donorDonor (MUD) with human histocompatibility antigens (HL-A) that meet DHCS standards. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Health Network Member | A Member who is enrolled in, or receives all Covered Services from a Health Network. |
| Kaiser Member | A Member who is enrolled in, or receives all Covered Services, from Kaiser Foundation Health Plan. |
| Medically Necessary or Medical Necessity | Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.<br><br>For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine |

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| Term | Definition |
|---|---|
| | Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. |
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Routine Care | Planned specialized intervention for health care needs. Routine authorization requests must meet this criterion. |
| Solid Organ Transplant | A Transplant for:<br><br>1. Heart;<br>2. Heart and lung;<br>3. Lung;<br>4. Liver;<br>5. Small bowel;<br>6. Kidney;<br>7. Combined liver and kidney;<br>8. Combined liver and small bowel; and<br>9. Combined kidney and pancreas. |
| Status 7 | Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center. |
| Transjugular intrahepatic portosystemic shuntIntrahepatic Portosystemic Shunt (TIPS) | A surgically created connection within the liver between the portal and systemic circulations. A TIPS is placed to reduce portal pressure in patients with complications related to portal hypertension. |
| Transplant | A non-experimental procedure for human tissue or organ transplantTransplant. |
| Transplant Center Hold | Temporarily unsuitable for the evaluation process according to the DHCS-approved Transplant Center. |
| Transplant Packet | All clinical information related to the evaluation process of a Member who has completed his or her Transplant work-up. |
| Urgent Care | Care that is needed for an unexpected illness or injury and the service cannot be delayed. Urgent authorization requests must meet this criterion.An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening the disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours. |
| Ventricular Assistive Device (VAD) | A mechanical pump that is utilized to assist the heart to pump blood through the body. |
| Whole-Child Model (WCM) | An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. |

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

# ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21, refer to California Children's Services (CCS)

**Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607**

**PHASE:** ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

**Patient Name:** ______________________ (Last) ______________________ (First) ☐ M ☐ F **D.O.B.** __________ **Age:** __________

**Mailing Address:** ______________________ **City:** ______________ **ZIP:** __________ **Phone:** __________

**Client Index # (CIN):** ______________________

**Referring Provider:**

**Provider NPI#:** ______________ **TIN#:** ______________

**Medi-Cal ID#:** ______________________

**Address:** **Phone:** ______________

**Fax:** ______________

**Office Contact:** ______________________

**Physician's Signature:** ______________________

**Diagnosis:** ______________________ **ICD-9:** __________

**TRANSPLANT TYPE**
(CalOptima may redirect based on contract status or center availability)

| | | |
|---|---|---|
| **BMT:** | ☐ Cedars | |
| **DLI:** | ☐ Cedars | |
| **Kidney:** | ☐ UCI | |
| **Kidney Pancreas:** | ☐ California Pacific | ☐ UCSF |
| **Liver:** | ☐ Cedars | ☐ USC |
| **Liver and Kidney:** | ☐ Cedars | ☐ USC |
| **Lung:** | ☐ USC | |
| **Heart:** | ☐ Cedars | ☐ USC |
| **Heart and Lung:** | ☐ Stanford | |
| **Small Bowel:** | ☐ Cedars | ☐ USC |

## AUTHORIZATION REQUEST

☐ **Inpatient** **Estimated Length of Stay:** ______________________

☐ **Outpatient** ☐ **Letter of Agreement (LOA) Requested**

**Date(s) of Service:** ______________________ **Retro Date(s) of Service:** ______________________

**List ALL procedures requested along with the appropriate CPT/HCPCS**

| REQUESTED PROCEDURES | PERTINENT HISTORY (Submit supporting medical records) | CODE (CPT or HCPCS) | QUANTITY (REQUIRED) |
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**DO NOT WRITE BELOW THIS LINE** **FOR CalOptima USE ONLY**

| **STATUS** | **Authorization Number #** |
|---|---|
| ☐ Approved ☐ Modified ☐ Denied | **Signature:** **Date:** |
| ☐ Not Medically Indicated ☐ Not a Covered Benefit | **Comments:** |
| ☐ Services Available In Network | |

Policy: GG.1313
Title: **Coordination of Care for Transplant Members**
Department: Medical Management
Section: Case Management

*CEO Approval:* */s/*

Effective Date: 01/01/2000
Revised Date: TBD

Applicable to:
☒ Medi-Cal
☐ OneCare
☐ OneCare Connect
☐ PACE
☐ Administrative

For 20210506 BOD Review Only

1 **I. PURPOSE**
2
3 This policy defines the Case Management guidelines for coordination of care by CalOptima and a
4 Health Network for a Member who is a candidate for Bone Marrow Transplant (BMT) or a Solid Organ
5 Transplant.
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7 **II. POLICY**
8
9 A. A Transplant shall be a Covered Service in accordance with CalOptima Policy GG.1105: Coverage
10 of Organ and Tissue Transplants.
11
12 B. If a Health Network Member, including a Whole Child Model (WCM) Member, except a Kaiser
13 Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and
14 the Health Network shall provide Case Management of the Member as follows:
15
16 1. Referral and Evaluation phase:
17
18 a. CalOptima shall provide Case Management for Covered Services directly related to the
19 Transplant referral and evaluation.
20
21 b. The Health Network shall provide Case Management for all other Covered Services
22 including, but not limited to, the management of Ventricular Assistive Device (VAD)
23 procedures, Dialysis, and Transjugular Intrahepatic Portosystemic Shunt (TIPS) procedures.
24
25 2. For Listed, Transplant, and post-Transplant phases (up to three-hundred-sixty-five (365)
26 calendar days post-Transplant): CalOptima shall provide Case Management for all Covered
27 Services.
28
29 C. CalOptima shall be responsible for providing Case Management to a Member who is enrolled in
30 CalOptima Direct, including a WCM Member, and who is identified as a candidate for BMT or a
31 Solid Organ Transplant.
32
33 D. Kaiser Foundation Health Plan, Incorporated (Kaiser) shall provide Case Management to a Kaiser
34 Member who is a potential candidate for BMT or a Solid Organ Transplant and shall assist such
35 Kaiser Member with coordination of care throughout the Transplant process in accordance with the
36 provisions of Section III.B of this policy.

E. CalOptima shall direct a CalOptima Direct Member or a Health Network Member, except a Kaiser Member, to the appropriate Department of Health Care Services (DHCS)-approved Transplant Center, or to a Designated Special Care Center for Members with a California Children's Services (CCS)-Eligible Condition, as applicable.

1. Kaiser shall direct a Kaiser Member to the appropriate DHCS-approved Transplant Center, as needed, or to a Designated Special Care Center for Members with a CCS-Eligible Condition, as applicable.

F. CalOptima shall provide ongoing education, collaboration, and oversight of Health Network case managers performing Case Management to a Member who is a candidate for BMT or a Solid Organ Transplant.

## III. PROCEDURE

A. If a Health Network Member (except a Member enrolled in Kaiser) or CalOptima Direct Member, is identified as a potential candidate for BMT or a Solid Organ Transplant, CalOptima and the Health Network shall provide Case Management of the Member as follows:

1. Referral Phase

a. A Provider shall identify a Member as a potential candidate for BMT or a Solid Organ Transplant.

i. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals, and shall request authorization from the Member's Health Network for all other Covered Services in accordance with requirements set forth by the Health Network.

ii. If the Member is enrolled in CalOptima Direct, the Provider shall request authorization for Covered Services in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

b. If a Health Network receives a request for authorization for a Transplant evaluation:

i. The Health Network shall notify the Provider to request authorization from CalOptima and shall forward the request to CalOptima's Utilization Management Department within one (1) working day after receipt.

ii. The Health Network case manager shall notify the CalOptima case manager that the Member is a potential candidate for BMT or a Solid Organ Transplant by sending an Adult Transplant Notification and Request Form by facsimile, to CalOptima's Case Management Department within:

1) Five (5) working days after identifying the Member for Routine Care; and

2) Twenty-four (24) hours or the next working day after identifying the Member for Urgent Care.

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iii. The Health Network case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iv. The Health Network case manager shall complete an initial assessment and create a care plan appropriate for the Member. The Health Network case manager shall update the assessment and care plan as the Member's status changes.

c. If the Member is enrolled in CalOptima Direct, or if CalOptima receives a request for authorization for a Transplant Evaluation for a Health Network Member:

i. The CalOptima Case Management Department shall open a case for Case Management.

ii. The CalOptima case manager shall place an introductory call to the Member within:

1) Five (5) working days after opening the case for Routine Care; and

2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

iii. After opening a Transplant case to Case Management, the CalOptima case manager shall complete an initial assessment and create a care plan appropriate for the Member. The CalOptima case manager shall update the assessment and care plan as the Member's status changes.

iv. The CalOptima case manager shall mail a Transplant information packet to the Member within five (5) working days after receipt of written notification. The case manager shall contact the Member by telephone within ten (10) working days after mailing the packet to ensure that the Member received the information and to address any questions or concerns that the Member may have.

v. The CalOptima case manager will coordinate with a DHCS-approved Transplant Center or a Designated Special Care Center for Members with a CCS-Eligible Condition, to facilitate completion of the referral.

2. Evaluation Phase

a. A DHCS-approved Transplant Center or a Designated Special Care Center shall request authorization for Transplant evaluation from CalOptima. If the Health Network receives the authorization for a Transplant evaluation from the DHCS-approved Transplant Center, or at a Designated Special Care Center the Health Network shall forward the request to the CalOptima Case Management Department within one (1) working day.

b. The CalOptima Utilization Management Department shall provide authorization for a Transplant evaluation at the DHCS-approved Transplant Center or at the Designated Special Care Center, as applicable, within the following timeframes:

i. Five (5) working days after receipt of a request and information needed to make a decision regarding Medical Necessity for Routine Care; and

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ii. Seventy-two (72) hours for Urgent Care.

c. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for BMT or a Solid Organ Transplant.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to identify any issues that may prevent the Member from completing the evaluation and to assist the Member with coordinating the evaluation.

e. Upon completion of a Member's evaluation, and approval for listing, the DHCS-approved Transplant Center or a Designated Special Care Center shall submit a Transplant Packet and request for authorization for Transplant to CalOptima for review within the following timeframes:

i. Five (5) working days after receipt of a request for Routine Care; and

ii. Twenty-four (24) hours or the next working day after receipt of a request for Urgent Care.

f. CalOptima shall notify the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and the Member's Health Network of the outcome of CalOptima's Chief Medical Officer's (CMO) or Designee's review, including CalOptima's approval or denial of the Transplant within the timeframes set forth in the CalOptima Utilization Management (UM) Program.

g. The CalOptima case manager shall verify Member eligibility on a monthly basis and shall notify the Member's Health Network case manager and the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, of any changes in the Member's eligibility.

3. Listing Phase

a. The Member's Health Network shall immediately notify CalOptima upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for BMT.

b. Upon notice from a DHCS-approved Transplant Center or a Designated Special Care Center, for a Health Network that a Member is listed for a Solid Organ Transplant or is approved for BMT, the CalOptima case manager shall notify the CalOptima Customer Service Department. The CalOptima Customer Service Department shall transition the Member to CalOptima Direct, effective the first (1st) calendar day of the month after the date CalOptima receives the above notice in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

c. The CalOptima case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center, as applicable, and authorize Covered Services for the Member, as appropriate.

d. The CalOptima case manager shall follow-up with the Member as necessary, based on the severity and complexity of the Member's case, to coordinate a Member's care and identify

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any issues which may lead to the Member's listing being placed in Status 7 or to removal from Transplant listing.

4. Transplant Phase and Post-Transplant Phase

   a. The CalOptima case manager shall follow the Member's progress during the hospital admission for the Transplant and coordinate with the facility case manager to ensure that all discharge needs are met.

   b. Upon the Member's discharge, the CalOptima case manager shall provide ongoing communication with a Member as the severity and complexity of the case requires, but not less than on a monthly basis, to address any issues and to assist in coordinating follow-up care.

   c. CalOptima shall provide Case Management for three-hundred-sixty-five (365) calendar days after the Transplant.

   d. At three-hundred-sixty-five (365) calendar days post-Transplant, the CalOptima case manager shall discuss any Member issues with the Member, including selection of a Health Network in accordance with CalOptima Policy DD.2008: Health Network Selection, and shall transition the Member's care to the Member's selected Health Network if the Member wishes to transition to a Health Network.

   e. The CalOptima case manager shall close the Member's case upon:

      i. The Member's transition to a Health Network; or

      ii. When goals are met, or the case meets closure criteria for CalOptima Direct Members.

B. If Kaiser identifies a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant, Kaiser shall provide Case Management of the Member as follows:

1. Referral Phase

   a. Kaiser is responsible for identifying a Kaiser Member as a potential candidate for BMT or a Solid Organ Transplant.

   b. The Kaiser case manager shall notify the CalOptima case manager, by submitting a Notification of Transplant Member form, that the Member is a potential Transplant candidate within five (5) working days after the Member is identified and shall open the case to Case Management.

   c. After opening a Transplant case to Case Management, the Kaiser case manager shall:

      i. Place an introductory call to the Member within:

         1) Five (5) working days after opening the case for Routine Care; and

         2) Twenty-four (24) hours or the next working day after opening the case for Urgent Care.

      ii. Complete an initial assessment and create a care plan appropriate for the Member;

      iii. Update the assessment and care plan as the Member's status changes; and


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iv. Notify the CalOptima case manager, in writing, of any significant changes in the Member's status.

d. The CalOptima case manager shall update the medical management system and complete the Transplant reporting script for Kaiser Transplants on a monthly basis.

e. The Kaiser case manager shall mail a Transplant information packet to the Member within five (5) working days after notification. The case manager shall place a follow-up call to the Member ten (10) days after mailing the packet to ensure that the Member received the packet and to address any questions or concerns that the Member may have.

2. Evaluation Phase

a. Kaiser shall direct a Kaiser Member identified as a potential candidate for BMT or a Solid Organ Transplant to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, for evaluation.

b. Kaiser shall provide authorization to a DHCS-approved Transplant Center or a Designated Special Care Center, as applicable, in order to ensure that the DHCS-approved Transplant Center or the Designated Special Care Center completes the Transplant evaluation.

c. If a DHCS-approved Transplant Center or a Designated Special Care Center places a Kaiser Member on Transplant Center Hold, the Kaiser case manager shall contact the CalOptima case manager with the Member's status including reason for the Transplant Center Hold and Kaiser's plan of action to resolve the issue. The CalOptima case manager shall document this information in the Transplant database.

d. Upon completion of the Transplant evaluation, Kaiser shall review the Transplant Packet and approve or deny the Transplant in pursuant to timeframes set forth in the CalOptima UM Program.

f. The Kaiser case manager shall follow-up with the Member as the severity and complexity of the case requires, but not less than on a monthly basis, to address any issues that may prevent the Member from completing the Transplant evaluation.

3. Listing Phase

a. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or the Designated Special Care Center for a Member who is in the listed phase or who is in Status 7 and shall authorize Covered Services related to the Transplant and the medical management of the Member.

4. Transplant Phase and Post-Transplant Phase

a. The Kaiser case manager shall follow a Member's progress during the Member's hospital admission for the Transplant, coordinate with the DHCS-approved Transplant Center's case manager or the Designated Special Care Center's case manager, to ensure that all discharge needs are met, and notify CalOptima of the Member's Transplant date within three (3) working days after the date of Transplant.

b. The Kaiser case manager shall continue to coordinate with the DHCS-approved Transplant Center or with the Designated Special Care Center and provide authorizations as needed for follow-up care.

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c. The Kaiser case manager shall provide ongoing Case Management of a Member as the complexity and severity of the case requires, but not less than once monthly, for three hundred sixty-five (365) calendar days after the Transplant.

d. The Kaiser case manager shall notify the CalOptima case manager, in writing, within five (5) working days after closing a case.

5. Kaiser shall submit reports to CalOptima in accordance with CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports.

## IV. ATTACHMENT(S)

A. Adult Transplant Notification and Request Form

## V. REFERENCE(S)

A. Contract for Health Care Provider Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
G. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy HH.2002Δ: Sanctions
K. Flow Chart: Coordination of Care for Transplant Members – CalOptima Direct and Health Networks

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency |
|---|---|
| 03/29/2016 | Department of Health Care Services (DHCS) |
| 10/09/2017 | Department of Health Care Services (DHCS) |

## VII. BOARD ACTION(S)

Not Applicable

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/2000 | GG.1313 | Coordination of Care for Members Eligible for Organ Transplants and Health Network Eligibility for Transplant Service Reimbursement | Medi-Cal |
| Revised | 11/01/2001 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |

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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 01/01/2006 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 03/01/2014 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 01/01/2016 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 09/01/2017 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | 09/01/2018 | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |
| Revised | TBD | GG.1313 | Coordination of Care for Transplant Members | Medi-Cal |

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1 **IX. GLOSSARY**
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| Term | Definition |
|---|---|
| Administrative Hold | A cease in reimbursement by CalOptima for Covered Services related to a Transplant evaluation to a Health Network pending resolution of administrative issues. CalOptima's Transplant Committee reviews all Administrative Hold cases on an individual basis. |
| Bone Marrow Transplant (BMT) | A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated Donor (MUD) with human histocompatibility antigens (HL-A) that meet Department of Health Care Services (DHCS) standards. |
| California Children Services Program (CCS) | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9. |
| California Children Services (CCS) Eligible Conditions | Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9. |
| CalOptima Direct | A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct. |
| Case Management | A systematic approach to coordination of care for a patient with special needs and or complex medical conditions that includes the elements of assessment, care planning, interventions monitoring, and documentation. |
| Covered Services | Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. |
| Designated Special Care Center | Centers that provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions. |

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| Term | Definition |
|---|---|
| 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. |
| Department of Health Care Services (DHCS) | The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs. |
| DHCS-approved Transplant Center | A facility that is approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal Transplants, a DHCS-approved Transplant Center is a facility that:<br><br>1. Is certified for, and participates in, the Medicare program; and<br>2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program. |
| Dialysis | A medical procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances. This is a procedure often performed on individuals with extremely poor kidney function. |
| Donor | An individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant. For a BMT, the Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated Donor (MUD) with human histocompatibility antigens (HL-A) that meet DHCS standards. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Health Network Member | A Member who is enrolled in or receives all Covered Services from a Health Network. |
| Kaiser Member | A Member who is enrolled in, or receives all Covered Services, from Kaiser Foundation Health Plan. |
| Medically Necessary or Medical Necessity | Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.<br><br>For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. |
| Member | A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services |

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| Term | Definition |
|---|---|
| | (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. |
| Routine Care | Planned specialized intervention for health care needs. Routine authorization requests must meet this criterion. |
| Solid Organ Transplant | A Transplant for:<br><br>1. Heart;<br>2. Heart and lung;<br>3. Lung;<br>4. Liver;<br>5. Small bowel;<br>6. Kidney;<br>7. Combined liver and kidney;<br>8. Combined liver and small bowel; and<br>9. Combined kidney and pancreas. |
| Status 7 | Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center. |
| Transjugular Intrahepatic Portosystemic Shunt (TIPS) | A surgically created connection within the liver between the portal and systemic circulations. A TIPS is placed to reduce portal pressure in patients with complications related to portal hypertension. |
| Transplant | A non-experimental procedure for human tissue or organ Transplant. |
| Transplant Center Hold | Temporarily unsuitable for the evaluation process according to the DHCS-approved Transplant Center. |
| Transplant Packet | All clinical information related to the evaluation process of a Member who has completed his or her Transplant work-up. |
| Urgent Care | An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening the disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours. |
| Ventricular Assistive Device (VAD) | A mechanical pump that is utilized to assist the heart to pump blood through the body. |
| Whole-Child Model (WCM) | An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. |

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

# ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21, refer to California Children's Services (CCS)

**Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607**

**PHASE:** ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

**Patient Name:** ______________________________ ☐ M ☐ F D.O.B. __________ Age: __________
Last First

**Mailing Address:** ______________________ City: ______________ ZIP: ________ Phone: __________

**Client Index # (CIN):** ______________________

| | TRANSPLANT TYPE (CalOptima may redirect based on contract status or center availability) | | |
|---|---|---|---|
| **Referring Provider:** | | | |
| **Provider NPI#:** __________ **TIN#:** __________ | **BMT:** | ☐ Cedars | |
| **Medi-Cal ID#:** ______________________ | **DLI:** | ☐ Cedars | |
| **Address:** **Phone:** __________ | **Kidney:** | ☐ UCI | |
| **Fax:** __________ | **Kidney Pancreas:** | ☐ California Pacific | ☐ UCSF |
| **Office Contact:** ______________________ | **Liver:** | ☐ Cedars | ☐ USC |
| **Physician's Signature:** ______________________ | **Liver and Kidney:** | ☐ Cedars | ☐ USC |
| | **Lung:** | ☐ USC | |
| **Diagnosis:** ______________ **ICD-9:** ______ | **Heart:** | ☐ Cedars | ☐ USC |
| | **Heart and Lung:** | ☐ Stanford | |
| | **Small Bowel:** | ☐ Cedars | ☐ USC |

## AUTHORIZATION REQUEST

☐ Inpatient **Estimated Length of Stay:** ______________________

☐ Outpatient ☐ Letter of Agreement (LOA) Requested

**Date(s) of Service:** ______________________ **Retro Date(s) of Service:** ______________________

**List ALL procedures requested along with the appropriate CPT/HCPCS**

| REQUESTED PROCEDURES | PERTINENT HISTORY (Submit supporting medical records) | CODE (CPT or HCPCS) | QUANTITY (REQUIRED) |
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| STATUS | Authorization Number # |
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| ☐ Approved ☐ Modified ☐ Denied | Signature: Date: |
| ☐ Not Medically Indicated ☐ Not a Covered Benefit | Comments: |
| ☐ Services Available In Network | |

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# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**
6. Consider Extension of Ancillary Services Contracts

**Contacts**
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

**Recommended Action**
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend Ancillary Services contracts, through June 30, 2022, under the same terms and conditions

**Background/Discussion**
CalOptima currently contracts on a fee-for-service basis with many ancillary providers to provide health care services to Medi-Cal, OneCare, OneCare Connect, PACE, and MSSP members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors. Staff is requesting authority to extend the existing Ancillary Services contracts through June 30, 2022, under the same terms and conditions.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted ancillary provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

**Fiscal Impact**
Management will include medical expenses related to the contract extensions in the upcoming Fiscal Year 2021-22 Operating Budget. To the extent there is any additional fiscal impact prior to the end of the fiscal year, such impact will be addressed in separate Board actions.

**Rationale for Recommendation**
CalOptima staff recommends this action to maintain and continue the contractual relationship with the ancillary provider network and to fulfill regulatory requirements.

**Concurrence**
Gary Crockett, Chief Counsel

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**Attachment**

1. Contract Template: Ancillary Services Contract for FFS Ancillary Providers

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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# ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _______________________ ("Provider"), with respect to the following:

## RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

## ARTICLE 1
## DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract:

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.3 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.4 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.5 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.5.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.5.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.6 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.7 "CalOptima Programs" means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.8 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.9 "CCS Providers" or "CCS-Paneled Providers(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.10 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.11 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.12 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.13 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.14 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.15 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.16 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.17 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.18 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

1.19 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.20 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.21 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.22 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.23 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.24 "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.25 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.26 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

1.27 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.28 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.29 "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.30 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.31 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.32 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.
PACE Services shall include the following:

a. All Medicare-covered items and services

b. All Medi-Cal covered items and services; and

c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.33 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.34 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.35 Whole Child Model Program" or "WCM", means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

## ARTICLE 2
## FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in

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accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or participation status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to Health Networks the same terms regarding Provider performance, duties and obligation and rates for Covered Services provided to CalOptima Members enrolled in Health Networks. Provider agrees to contract with a Health Network(s) upon the request of a Health Network(s).

2.12 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities

as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.13 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.14 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.15 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.16 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials

in the threshold languages identified by CalOptima at no higher than the sixth (6th) grade reading level.

2.17 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.18 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.19 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive

Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.20 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.21 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any

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employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.22 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.23 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government

Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.24 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.24.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.24.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.24.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.24.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients.

2.24.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.24.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

2.24.7 An agreement to comply with CalOptima's Compliance Program.

2.24.8 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.25 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.26 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.26.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.26.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.26.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this

Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.26.4 Provider shall include the obligations of this Section in its Subcontracts.

2.26.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.27 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

2.28 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.29 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.30 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.31 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.32 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.33 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to

execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the Provider shall follow CCS Program Guidelines, including CCS Program regulations, and where CCS Clinical guidelines do not exist, Provider will use evidence -based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.35 CCS Provider Compliance.

2.35.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.35.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.35.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.35.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.36 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.37 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.38 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

## ARTICLE 3
## FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

**ARTICLE 4**
**PAYMENT PROCEDURES**

4.1 Billing and Claims Submission. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.7.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.7.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.7.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.8.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

## ARTICLE 5
## INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and

employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

## ARTICLE 6
## RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

## ARTICLE 7
## TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2020. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and

responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of

reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.9 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

## ARTICLE 8
## GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

## ARTICLE 9
## GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

______________________________
Name

______________________________
Title

______________________________
Address

______________________________

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this

Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Provider covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

**ARTICLE 10**
**EXECUTION**

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

| **Provider** | **CalOptima** |
|---|---|
| ______________________ Signature | ______________________ Signature |
| ______________________ Print Name | Ladan Khamseh Print Name |
| ______________________ Title | Chief Operating Officer Title |
| ______________________ Date | ______________________ Date |

## ATTACHMENT A

## COVERED SERVICES

## ARTICLE 1
## CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Medi-Cal Program

_______ Medicare Advantage Program (OneCare)

_______ PACE Program

_______ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

## ARTICLE 2
## SERVICES

2.1 Scope of Covered Services. "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:

@@Custom Field{Ancillary Scope of Covered Service}@@

# ATTACHMENT B
# PROCEDURES FOR REQUESTING INTERPRETATION SERVICES
## ARTICLE 1
## CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) and PACE with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD and PACE Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

## ARTICLE 2
## HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

**ATTACHMENT C**
**COMPENSATION**

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

**I. Medi-Cal Program Reimbursement**

For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

**II. Medicare Advantage (OneCare) Program Reimbursement**

For Medicare Advantage (OneCare) Members, CalOptima shall reimburse for Covered Services as follows:

**III. PACE Program Reimbursement**

For PACE Members, CalOptima shall reimburse for Covered Services as follows:

**IV. Cal MediConnect (OneCare Connect) Program Reimbursement**

For Cal MediConnect (OneCare Connect) Members, CalOptima shall reimburse for Covered Services as follows:

**ATTACHMENT D**

**DISCLOSURE FORM**

________________________________________

Name of Provider

The undersigned hereby certifies that the following information regarding

________________________________________ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

__________________________________________________________________________

__________________________________________________________________________

Co-Owner(s):

__________________________________________________________________________

__________________________________________________________________________

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

__________________________________________________________________________

__________________________________________________________________________

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

__________________________________________________________________________

__________________________________________________________________________

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

__________________________________________________________________________

__________________________________________________________________________

Dated: ____________________________

Signature: __________________________________

Name: _____________________________________

(Please type or print)

Title: ______________________________________

(Please type or print)

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**ADDENDUM 1**
**MEDI-CAL PROGRAM**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

   Provider shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3 Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

7. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

8. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

9. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through the DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

   Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

   11.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

   11.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

   11.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

12.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

12.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

12.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

12.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

12.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

12.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

12.1.6 Will include a clause entitled, “Debarment and Suspension Certification” that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

12.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

12.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

12.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

13. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

14. Lobbying Restrictions and Disclosure Certification.

14.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2 Certification and Disclosure Requirements

14.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph 14.3 of this provision.

14.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using

nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 14.3 of this provision if paid for with appropriated funds.

14.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

14.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements.

15.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

15.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed

in accordance with all laws and applicable regulations governing the DHCS Contract.

15.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.23 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

15.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 16 of this Addendum 1.

15.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.7 of the Contract.

15.2.10 An agreement to notify DHCS in the manner provided in Section 7.9 of the Contract in the event the Subcontract is amended or terminated.

15.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.17 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.16 or the Contract.

15.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

15.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5. of the Contract.

15.2.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

15.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

16. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

18 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider

or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

# 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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

| 1. Type of Federal Action:<br>contract<br>grant<br>cooperative agreement loan<br>loan guarantee<br>loan insurance | 2. Status of Federal Action:<br>bid/offer/application<br>initial award<br>post-award | 3. Report Type:<br>initial filing<br>material change<br>For Material Change Only:<br>Year _____ quarter_______ date of last report |
|---|---|---|

| 4. Name and Address of Reporting Entity:<br>Prime Subawardee<br>Tier , if known:<br><br>Congressional District, If known: | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:<br><br>Congressional District, If known: |
|---|---|
| 6. Federal Department/Agency: | Federal Program Name/Description:<br><br>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):<br><br>(attach Continuation Sheets(s) | b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):<br><br>SF-LLL-A, If necessary) |
| Amount of Payment (check all that apply):<br>$ actual planned | 13. Type of Payment (Check all that apply):<br>a. retainer<br>b. one-time fee<br>c. commission<br>d. contingent fee<br>e. deferred<br>f. other, specify: |
| Form of Payment (check all that apply):<br>a. cash<br>b. in-kind, specify: Nature<br><br>Value | |

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

| 16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure. | Signature:<br>Print Name:<br>Title:<br>Telephone No.: Date: |
|---|---|
| **Federal Use Only** | Authorized for Local Reproduction<br>Standard Form-LLL |

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D C 20503.

**ADDENDUM 2**
**MEDICARE ADVANTAGE PROGRAM**
**(ONECARE)**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Provider agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, DHHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

   (b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

   (c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set forth in this Contract. Moreover, CalOptima shall have the right to require Provider to

terminate any Subcontracting provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review and approve Provider's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Provider agrees to comply with MSP requirements. Provider shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Provider Authority to Bill Third Party Payers. Provider may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Provider Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Provider may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Provider agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Provider bills a third party payor as primary. Provider agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Provider, or, CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

# 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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

| 1. Type of Federal Action: | 2. Status of Federal Action: | 3. Report Type: |
|---|---|---|
| contract<br>grant<br>cooperative agreement loan<br>loan guarantee<br>loan insurance | bid/offer/application<br>initial award<br>post-award | initial filing<br>material change<br>For Material Change Only:<br>Year _____ quarter_______ date of last report |

4. Name and Address of Reporting Entity:

Prime Subawardee

Tier , if known:

Congressional District, If known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:

6. Federal Department/Agency:

Federal Program Name/Description:

CDFA Number, if applicable:

8. Federal Action Number, if known:

9. Award Amount, if known:

10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):

(attach Continuation Sheets(s)

b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):

SF-LLL-A, If necessary)

Amount of Payment (check all that apply):

$ actual planned

Form of Payment (check all that apply):

a. cash
b. in-kind, specify: Nature

Value

13. Type of Payment (Check all that apply):

a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.

Signature:

Print Name:

Title:

Telephone No.: Date:

**Federal Use Only**

Authorized for Local Reproduction
Standard Form-LLL

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

## ADDENDUM 3

## PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 3 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1. This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2. Amendments to this Contract and amendments to any subcontract agreements between Provider and subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3. CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees. Provider shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1. Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2. Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3. Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

   2.6. Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

   2.7. Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory

obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8. Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9. Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10. Provision of Direct Care Services to PACE Participants. Provider hereby represents and warrants that Provider and all employees of Provider providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Provider agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Provider or any employee of Provider providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.10.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2.10.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Provider furnishes;

2.10.3 Have verified current certifications or licenses for their respective positions;

2.10.4 Have not been excluded from participation in Medicare, Medicaid or Medi-Cal;

2.10.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2.10.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2.10.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2.10.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.11. The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its

Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

13. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

13.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.1.2 herein; and

13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

13.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

13.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

15. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

16. Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in this Addendum 3.

16.1 (Applicable to federally funded contracts in excess of $100,000, per Section 1352 of the 31, U.S.C.)

16.2 Certification and Disclosure Requirements

16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 3, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 16.3 of this provision.

16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to Addendum 3, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 16.3 of this provision if paid for with appropriated funds.

16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure, or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides, in part, that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

17. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:
   - contract
   - grant
   - cooperative agreement
   - loan
   - loan guarantee
   - loan insurance

2. Status of Federal Action:
   - bid/offer/application
   - initial award
   - post-award

3. Report Type:
   - initial filing
   - material change

   For Material Change Only:

   Year _____ quarter_______
   date of last report

4. Name and Address of Reporting Entity:

   Prime    Subawardee

   Tier    , if known:

   Congressional District, If known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

   Congressional District, If known:

6. Federal Department/Agency:

Federal Program Name/Description:

CDFA Number, if applicable:

8. Federal Action Number, if known:

9. Award Amount, if known:

10. a. Name and Address of Lobbying Entity
   (If individual, last name, first name, MI):

   b. Name and Address of Lobbying Entity
   (If individual, last name, first name, MI):

   (attach Continuation Sheets(s) SF-LLL-A, If necessary)

Amount of Payment (check all that apply):

$ actual planned

Form of Payment (check all that apply):

a. cash
b. in-kind, specify: Nature

Value

13. Type of Payment (Check all that apply):
   - a. retainer
   - b. one-time fee
   - c. commission
   - d. contingent fee
   - e. deferred
   - f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.

Signature:

Print Name:

Title:

Telephone No.: Date:

**Federal Use Only**

Authorized for Local Reproduction
Standard Form-LLL

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

**ADDENDUM 4**
**CAL MEDICONNECT PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Provider shall provide services or perform other activity pursuant to this Contract in accordance with (i) applicable DHCS and CMS laws, regulations, instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS.

2. Provider shall (i) safeguard Member privacy and confidentiality of Member health records (ii) comply with all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.

3. The performance of the Provider and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

4. Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.

5. Provider shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Provider shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth ($6^{th}$) grade reading level.

7. Provider shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.

8. Provider shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of Provider. Provider may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Provider is compensated by the Contractor for services provided to the Member. CalOptima will not refuse to contract or pay Provider for the provision of covered services under the CalOptima Cal MediConnect Program solely because Provider has in good faith communicated or advocated on behalf of a Member as set forth above.

9. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to

suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Provider shall be responsible for any resulting overpayments.

10. Downstream Entity Contracts.

10.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414. Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

10.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 4 and Section 2.20 of the Contract.

10.1.2 An agreement to (i) Member financial protections in accordance with Section 4.7 of the Contract, including prohibiting Downstream Entities from holding an Member liable for payment of any fees that are the obligation of the Provider, and (ii) safeguard Member privacy and confidentiality of Member health records.

10.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 11 of this Addendum 4 and the reporting requirements of Section 5 of this Addendum 4.

10.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 12 of this Addendum 4 and 2.14 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 4.

10.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 13 of this Addendum 4.

10.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 14 of this Addendum 4.

10.1.7 Language that specifies the First Tier, Downstream and Related Entities must comply with the federal and state laws, regulations and CMS instructions.

10.1.8 Notify DHCS in the even the agreement with the subcontract is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

10.2 In addition to Section 10.1 of this Addendum 4, Provider shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

10.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Provider.

10.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

10.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 6 of this Addendum 4.

10.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 4.

10.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.7.1 of the Contract and Section 19 of this Addendum.

10.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 8 of this Addendum 4, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 16 of this Addendum 4.

10.2.7 An agreement that the medical provider assist the Provider and/or CalOptima in the transfer of care of a Member in accordance with Section 15 of this Addendum.

10.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 4, and (ii) to notify DHCS in the manner set forth in Section 7.9 of the Contract in the event the subcontract is amended or terminated.

10.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 18 of Addendum 4, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under the Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Provider and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

10.2.10 An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites in accordance with Section 2.17 of the Contract.

11. Right of Inspection, Evaluation, and Audit of Records. Provider and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

12. Provider and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.12 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Provider and/or its Downstream Entities have not performed satisfactorily.

13. Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review, approve, and audit Provider's credentialing process on ongoing basis.

14. Provider Terminations. In the event a provider is terminated for cause by Professional, Provider shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Provider terminates a provider for deficiencies in the quality of care provided, Provider shall give notice of the action to the appropriate licensing and disciplinary agencies.

15. In addition to Section 2.15 of the Contract, Provider agrees to assist CalOptima in the transfer of care of a Member. Provider shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

16. Provider is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

17. Assignment or Delegation. Provider agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Provider or Downstream Entity; (iii) the merger, reorganization, or consolidation of Provider or Downstream Entity, with another entity with respect to which Provider or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Provider or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Provider or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Provider agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Provider's or its Subcontractor's possession.

19. In addition to Section 4.7.1 of the Contract, Provider acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

**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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:
   contract
   grant
   cooperative agreement
   loan
   loan guarantee
   loan insurance

2. Status of Federal Action:
   bid/offer/application
   initial award
   post-award

3. Report Type:
   initial filing
   material change
   For Material Change Only:
   Year _____ quarter_______
   date of last report

4. Name and Address of Reporting Entity:
   Prime Subawardee
   Tier , if known:
   Congressional District, If known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
   Congressional District, If known:

6. Federal Department/Agency:

Federal Program Name/Description:
CDFA Number, if applicable:

8. Federal Action Number, if known:

9. Award Amount, if known:

10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
   (attach Continuation Sheets(s)

b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
   SF-LLL-A, If necessary)

Amount of Payment (check all that apply):
$ actual planned

Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature
Value

13. Type of Payment (Check all that apply):
   a. retainer
   b. one-time fee
   c. commission
   d. contingent fee
   e. deferred
   f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.

Signature:
Print Name:
Title:
Telephone No.: Date:

**Federal Use Only**

Authorized for Local Reproduction
Standard Form-LLL

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

7. Consider Extension of the Professional Services Contracts for clinics, Except Those Affiliated with Providence St. Joseph Healthcare

**Contacts**

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

**Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Professional Services contracts for clinics, except those affiliated with Providence St. Joseph Healthcare through June 30, 2022 under the same terms and conditions

**Background/Discussion**

CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal (CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A)), OneCare, OneCare Connect (including CCN) and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board. Staff is requesting authority to extend the Medi-Cal, OneCare Connect, and PACE FFS clinic Professional Services contracts, except those affiliated with Providence St. Joseph Healthcare, through June 30, 2022.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

**Fiscal Impact**

Management will include medical expenses related to the contract extensions in the upcoming Fiscal Year 2021-22 Operating Budget. To the extent there is any additional fiscal impact prior to the end of the fiscal year, such impact will be addressed in separate Board actions.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

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**Attachments**

1. Contract Template: Professional Services Contract for FFS Clinics

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

Back to Agenda

**PROFESSIONAL SERVICES CONTRACT**

**GENERAL PROVISIONS**

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and _______________________ ("Professional"), with respect to the following:

**RECITALS**

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract through the Practitioners listed on Attachment C to CalOptima Members, as identified in Attachment A.

H. CalOptima and Professional desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

**ARTICLE 1**

**ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES**

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Professional's Practitioners who own, are employed by, or under contract with, Professional, and who will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of

such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: Cal MediConnect Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

## ARTICLE 2
## DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 "Assigned Members" means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima's electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider's participation in the program.

2.7 "Behavioral Health Services" means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 "Cal MediConnect" is a program to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program. Cal MediConnect is also referred to as OneCare Connect.

2.9 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 "CalOptima Direct" or "COD" means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 "CalOptima Direct—Administrative" or "COD-Administrative," provides services to Members who reside outside of CalOptima's service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 "CalOptima Policies" means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 "CalOptima Program(s)" means the Medi-Cal, Cal MediConnect, and PACE Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 "Care Management Services" means (i) providing Physician Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member's care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 "CCS Provider(s)" or "CCS-Paneled Provider(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 "Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

2.38 "HealthCare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.39 "Health Risk Assessment" or "HRA" means the assessment tool which identifies a Member's primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 "Hospital Services" means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 "Hospitalist" means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 "Individualized Care Plan" or "ICP" means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

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2.43 "Interdisciplinary Care Team" or "ICT" means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 "Licenses" means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 "Medi-Cal Specialty Mental Health Services" mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 "Medical Necessity" or "Medically Necessary" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to

manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which

treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

**ARTICLE 3**
**FUNCTIONS AND DUTIES OF PROFESSIONAL**

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall provide CalOptima with the following information, as applicable: (a) names of all officers of Professional's governing board; (b) names of all owners of Professional; (c) names of stockholders owning more than five percent (5%) of the stock issued by Professional; and (d) names of major creditors holding more than five percent (5%) of the debt of Professional. Professional shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Professional shall notify CalOptima immediately of any changes to the information included by Professional in the disclosure forms submitted to CalOptima.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 CalOptima QMI Program. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Professional. Professional agrees that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Professional further agrees to participate in all quality improvement studies including, but not limited to HEDIS data collection. Professional shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Professional Services (*e.g.,* medical necessity) and shall accept as final all decisions regarding disputes over Physician Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

Professional shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional 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. Professional and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national

origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional'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.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, 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.

Professional and its Downstream Entities 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 Professional's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional's and its Subcontractors noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Professional may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional 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 Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any

advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Professional shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or

alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional 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. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a

significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima.

CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data."

## ARTICLE 4
## FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract.

## ARTICLE 5
## INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of

such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

## ARTICLE 6
## RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For

purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

## ARTICLE 7
## TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2021. This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract."

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

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7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally- approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

c) Cal MediConnect program beneficiaries as described in this Section shall be paid at the Medicare rate for services covered under the Medicare benefit. Services for benefits not covered by Medicare but covered under Medi-Cal, the Medi-Cal rate as stated in the above paragraph "a" shall apply.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

7.10.1 Professional shall not furnish services under CalOptima's Cal MediConnect program unless and until CalOptima is authorized by DHCS and CMS to proceed with such program and CalOptima provides written notice to Professional of the commencement date of such services.

## ARTICLE 8
## GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

## ARTICLE 9
## MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings

against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

______________________________
Name

______________________________
Title

______________________________
Address

______________________________

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in

good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional 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.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

9.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.17 Debarment Certification. Professional agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) 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.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

9.17.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

**ARTICLE 10**
**EXECUTION**

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

| Professional | CalOptima |
|---|---|
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | Ladan Khamseh |
| Print Name | Print Name |
| ______________________ | Chief Operating Officer |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

## ATTACHMENT A

## CONTRACTED SERVICES

### ARTICLE 1
### CALOPTIMA PROGRAMS AND SERVICES

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Cal-MediConnect Program (Members Dually Eligible for Medicare and Medi-Cal Benefit) Includes Community Network

__X__ Medi-Cal Program (Community Network and COD Administrative)

__X__ PACE Program

1.2 Physician Services. Professional shall furnish:

__X__ Primary Care Provider Covered Services to eligible Members in the CalOptima program, who are assigned to Professional.

__X__ Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

### ARTICLE 2
### GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services

must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member's care. Professional shall forward the results of diagnostic procedures and consultations to Member's assigned PCP in a timely manner in order to ensure that the Member's care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima's Policies and for periodicity and content of pediatric

health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall

include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

## ATTACHMENT B

## COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

## I. MEDI-CAL PROGRAM

### A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

   1.2. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

   1.3. NOT APPLICABLE TO THIS CONTRACT

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XXX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

   2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

### B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. **Specialist Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

   1.2. NOT APPLICABLE TO THIS CONTRACT

   1.3. **Non Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. NOT APPLICABLE TO THIS CONTRACT

1.5. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.6. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

| CPT Code Range | Type of Service | Fee Schedule |
|---|---|---|
| **10000-69999** | **Surgical Range** | |
| **70000-79999** | **Radiology and Radiation Therapy Professional and Technical Components** | |
| **80000-89999** | **Lab and Pathology** | |
| **90000-99999** | **Professional Services** | |
| **HCPC Codes** | | |

1.6.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

1.6.2. Subject to approval by the CalOptima Board of Directors, the specialist rates identified in Section 1.6 shall be extended effective **July 1, 2018**.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## II. PACE PROGRAM

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or
2. **XX** of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.
3. Prior authorization rules apply for payment of services.
4. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
5. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   5.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   5.2 Professional shall utilize current payment codes and modifiers for Medicare.
   5.3. CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   5.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.
6. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

## III. CAL MEDICONNECT

For Covered Services provided to Cal MediConnect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of:

1. Billed charges, or XX of the Current Medicare Allowable Participating Provider Fee Schedule for locality 26.
2. Prior authorization rules apply for payment of services.
3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   4.1 "By Report & Unlisted" codes will be paid at XX of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   4.2 Professional shall utilize current payment codes and modifiers for Medicare.
   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.
   4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

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## IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. NOT APPLICABLE TO THIS CONTRACT

8. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

9. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   9.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   9.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

9.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

9.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

9.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

**ATTACHMENT B-1**
**SUPPLEMENTAL COMPENSATION**
**PROPOSITION 56 FUNDING**

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services (both as defined in this Attachment B-1) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

   1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 increase in accordance with the Exhibit for the applicable State fiscal year attached to this Attachment, applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.

3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments for dates of service between July 1, 2017 and July 30, 2019 and beyond if so directed by DHCS.

4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

6. Notwithstanding other provisions of this Attachment B-1, effective July 1, 2020, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

**ATTACHMENT B-1, Exhibit 1**
**SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |

**ATTACHMENT B-1, Exhibit 2**
**SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |
| 99381 | Initial Comprehensive Preventive Med E&M (<1-year-old) | |
| 99382 | Initial Comprehensive Preventive Med E&M (1-4 Years old | |
| 99383 | Initial Comprehensive Preventive Med E&M (5-11 years old) | |
| 99384 | Initial Comprehensive Preventive Med E&M (12-17 Years old) | |
| 99385 | Initial Comprehensive Preventive Med E&M (18-39 Years old) | |
| 99391 | Periodic comprehensive preventive med E&M (<1-year-old) | |
| 99392 | Periodic comprehensive preventive med E&M (1-4 years old) | |
| 99393 | Periodic comprehensive preventive med E&M (5-11 years old) | |
| 99394 | Periodic comprehensive preventive med E&M (12-17 years old) | |
| 99395 | Periodic comprehensive preventive med E&M (18-19 years old) | |

## ATTACHMENT C

## PROFESSIONAL / PRACTITIONER

Professional's Name ______________________________

Address ______________________________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________________

Note: The email address will be used to send communication electronically when applicable. Please indicate the appropriate contact's email address.

Date ______________________

This Attachment may be amended from time to time, and shall incorporate Practitioners who (i.) own, are employed by, or under contract with, Professional, including locum tenens; and (ii.) will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima requirements and credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least 30 days prior to the effective date of such addition or deletion. CalOptima shall maintain the roster of Professional's Practitioners with the applicable effective date of addition and/or deletion. Please attach separate list with the information below, if necessary.

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**ATTACHMENT D**
**SPECIAL PROVISIONS**

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**ATTACHMENT E**

**DISCLOSURE FORM**

______________________________________________

Name of Provider

The undersigned hereby certifies that the following information regarding

____________________________________________ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

________________________________________________________________________

________________________________________________________________________

Co-Owner(s):

________________________________________________________________________

________________________________________________________________________

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

________________________________________________________________________

________________________________________________________________________

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

________________________________________________________________________

________________________________________________________________________

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

________________________________________________________________________

________________________________________________________________________

Dated: ____________________________

Signature: ______________________________________

Name: ______________________________________
(Please type or print)

Title: ______________________________________
(Please type or print)

**ADDENDUM 1**
**MEDI-CAL PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Programs: These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail. For purpose of this Addendum 1, "State Contract" means the written agreement between CalOptima and DHCS pursuant to which CalOptima is obligated to arrange and pay for the provision of Medi-Cal Covered Services to Members in Orange County, California.

1. Professional and other Providers of Services. Upon request, Professional shall provide CalOptima with a list of approved Practitioners providing Covered Services, together with any information requested by CalOptima for credentialing and/or the administration of its QMI Program. Professional shall, as warranted, immediately restrict or suspend Practitioners from providing Physician Services to Members when: (i) the Practitioner ceases to meet Minimum Provider Standards and/or other licensing/certification requirements or other professional standards described in this Contract; or (ii) CalOptima reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the applicable Practitioner that does or could adversely affect the health or safety of Members. Professional shall immediately notify CalOptima of any of Professional's Practitioner(s) who ceases to meet Minimum Provider Standards or licensing/certification requirements and Professional's action.

2. Emergency Services. Professional shall comply with all applicable State and Federal laws and regulations, as well as State Contract, Exhibit A, Attachment 8, Provision 13, governing the provisions and payment of Emergency Services including, without limitation, the following requirements:

    2.1 Professional shall furnish Emergency Services on a twenty four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Professional for Emergency services without Prior Authorization.

    2.2 Payment will not be denied where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 2.28.

    2.3 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

    2.4 The attending emergency Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

    2.5 Professional shall refer any Community Network Member not assigned to Professional back to the assigned Primary Care Provider, and shall facilitate the transfer of any applicable records to such Physician.

    2.6 Professional and Professional's Practitioners shall be and remain during the period of this Contract duly licensed to practice in their profession in the State of California or in the state in which Professional will be providing Physician Services to Members. Professional is currently in good standing, and at all times during the term of this Contract shall maintain good standing, with the following:

        2.6.1 all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

        2.6.2 certification under Medi-Cal and Medicare; and

        2.6.3 Board certification to the extent required by CalOptima Policies.

3. Hospital Admissions. Professional may not admit a Member to a hospital on a non-emergency basis without first receiving Prior Authorization from CalOptima's UM Department. Professional shall coordinate care with Hospitalists for Member hospital admissions and provide history, medications, referrals and previous work-up information.

4. Admissions to Long Term Care Facility. Professional shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Professional shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long-term care, Professional shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

5. Confidentiality of Sensitive Services Information. If a Professional supplies Sensitive Services, including Family Planning Services, Professional shall comply with State confidentiality laws, regulations and other requirements relating to Members' Family Planning information and records and Professional acknowledges that he or she is solely responsible for developing and implementing Policies and Procedures to ensure compliance with such confidentiality requirements. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Professional shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

6. Linguistic and Cultural Sensitivity Services. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its Policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level. Professional shall comply with the language assistance standards developed pursuant to Health & Safety Code section 1367.01.

7. Provision of Interpreters. Professional shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract and CalOptima Policies. Professional shall ensure provision of interpreter services to Members at all provider sites.

   Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Professional shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

   The provision of interpreter services required by this section may be undertaken in accordance with the Provider Manual and CalOptima Policy.

8. Overpayments and CalOptima Right to Recover. Professional has an obligation to report any overpayment identified by Professional, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Professional, or of receipt of notice of an overpayment identified by CalOptima. Professional acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Professional, CalOptima shall have the right to recover such amounts from Professional by recoupment or offset from current or future amounts due from CalOptima to Professional, after giving Professional notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Professional to CalOptima, including, but not limited to, amounts due because of:

8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

8.3 Unpaid Conlon reimbursements owed by Professional to a Member.

8.4 Payments made for services provided by a Professional that has entered into a private contract with a Medicare beneficiary for Covered Services.

9. Professional Subcontracts. If the Professional is an individual sole practitioner, the Professional shall not subcontract for the provision of Covered Services to Members.

10. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. CalOptima will reimburse Professional at the current CalOptima Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

11. Electronic Transactions. Professional agrees to engage in exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions.

12. Records Retention. Professional and its Subcontractors shall maintain and retain all records of all items and services provided to Members: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Professional's or Subcontractor's place of business or at such mutually agreeable location in California; and (c) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Physician's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

13. Access to Books and Records.

13.1 Professional agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and the State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Professional's place of business or at such other mutually agreeable location in California, (c) in a form maintained in accordance with the general

standards applicable to such book or record keeping, (d) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, and (e) including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Professional shall provide access to all security areas and shall provide reasonable cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Professional at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

13.2 Through the end of the records retention period specified in Section 13.1, above, Professional shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Professional pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 13.1, above, Professional shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Professional's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Professional's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations, as well as requirements of DHCS and this Contract.

13.3 Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of Professional's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Professional, Subcontractor, and provider facilities, management systems and procedures, and books and records, as the Director of DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Professional. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Professional will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Professional or the Subcontractor(s).

13.4 The provisions of this Section 13 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

14. Form of Records. Professional's books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

15. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Professional site.

16. Downstream Contracts. In the event that Professional is allowed to Subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS. Professional shall ensure that all Subcontracts are in writing and require that the Professional and its Subcontractors:

    16.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

    16.2 Retain such books and all records and documents through the end of the records retention period specified in Section 13.1

17. Assignment and Delegation. Professional agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Professional or Subcontractor; (iii) the merger, reorganization, or consolidation of Professional or Subcontractor with another entity with respect to which Professional or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Professional or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Professional or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

19. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional related to this Contract.

19.1 Professional further agrees to timely gather, preserve, and provide to DHCS any records in the Professional's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

20. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

21. LEFT BLANK INTENTIONALLY

22. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

23. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Providers 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 Professional, its employees, agents, or Providers as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Providers shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Providers shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional:

23.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

23.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

23.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

23.4 will, at the termination of this Contract, return all such information to CalOptima that Professional is not legally or contractually required to retain and make available, and maintain all other such information according to written procedures sent to the Professional by CalOptima for this purpose.

24. DHCS Directions. If required by DHCS, Professional shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

25. Additional Subcontracting Requirements. Professional shall require all Subcontractors that relate to the provision of Medi-Cal Covered Services to Members pursuant to this Contract include the following:

25.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

25.2 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

25.3 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

25.4 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 1, and (b) to notify DHCS in the manner provided in Section 7.10 of the Contract in the event the Subcontract is amended or terminated

25.5 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Section 3.38 of the Contract and Section 26 of this Addendum 1, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 19 and 19.1 of this Addendum 1.

25.6 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 13 of this Addendum 1.

25.7 An agreement to maintain and make available to DHCS, CalOptima, and/or Professional, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Sections 16.1 to 16.2 of this Addendum 1.

25.8 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies) and the requirements set forth in Section 27 of this Addendum 1.

25.9 An agreement to assist Professional and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 29 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section IV.9 of Attachment B of the Contract.

25.11 An agreement to the requirements for cultural and linguistic sensitivity and the provision of interpreter services to be provided as set forth in Sections 6 and 7 of this Addendum 1.

25.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal Members, as provided in CalOptima Policies relative to the Medi-Cal program, and excluding any contract disputes between Professional and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

25.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 3.17 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima, and/or Professional determines that the Subcontractor has not performed satisfactorily.

25.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 32 of this Addendum 1 and Section 6.5.3 of the Contract.

25.15 An agreement by the Professional to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.6 of the Contract.

25.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 to 6.3 of the Contract and Sections 12 to 13 of this Addendum 1.

25.17 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

26. Professional shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

27. Professional shall comply with (a) DHCS Medi-Cal Provider Bulletins and Manuals, (b) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and (c) all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

28. Professional shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by Professional pursuant to the Contract.

29. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Professional shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, and the continuity, to the extent possible, of Member-Provider relationships. Cost of reproduction shall be borne by DHCS and CalOptima as applicable.

29.1 Professional agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

30. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

31. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

32. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with the Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use it as the Professional is able for the purpose of Member care coordination.

**ADDENDUM 2**
**PACE PROGRAM REQUIREMENTS**

The terms and requirements of this Addendum 2 shall apply for services provided by Professional to Members who are enrolled in the CalOptima PACE program only. These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail.

1. State Approval and Termination.

    1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

    1.2 Amendments to this Contract and amendments to any subcontract agreements between Professional and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

    1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Professional of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Professional's Responsibilities applicable to providing services to CalOptima PACE Members. Professional shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE Members, Professional agrees to do the following:

    2.1 Professional shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

    2.2 Duties Related to Professional's Position. Professional shall perform all the duties related to its position, as specified in this Contract.

    2.3 Services Authorized. Professional shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

    2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Professional shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

    2.5 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Professional will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Professional pursuant to this Contract.

    2.6 Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.7 Coverage of Non-Network Providers. Professional agrees that should arrangements be made by Professional with another physician/provider who is not under contract with CalOptima to provider Covered Services required under this Contract, such physician/provider shall (a) accept Professional's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Professional's office, unless Professional has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.8 Participant Bill of Rights. Professional shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Professional.

2.9 Provision of Direct Care Services to PACE Participants. Professional hereby represents and warrants that Professional and all employees of Professional providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Professional agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Professional or any employee of Professional providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.9.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2. 9.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Professional furnishes;

2. 9.3 Have verified current certifications or licenses for their respective positions;

2. 9.4 Have not been excluded from participation in Medicare, or Medi-Cal;

2. 9.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2. 9.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2. 9.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2. 9.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Professional and PACE.

3. Records Retention. Professional and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving

matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Professional's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Professional and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Professional's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Professional shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Professional and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Professional may possess in order to verify Professional's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Practitioner or Subcontractor site.

6. Downstream Contracts. In the event that Professional is allowed to subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Professional, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions); (ii) the change

of more than twenty-five percent (25%) of the directors or trustees of Professional; (iii) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity; and/or (iv) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Professional, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For

the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Professional may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional or its Subcontractors, Professional:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

13. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

**ADDENDUM 3**
**CAL MEDICONNECT PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Professional shall provide services or perform other activity pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS,
2. Professional shall (i) safeguard Member privacy and confidentiality of Member health records, (ii) comply with all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Professional and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Professional shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Professional shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Professional shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Professional acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with hospital actions required to comply with EMTALA.
7. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
8. Professional shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
9. Professional shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Professional. Professional may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such Professional is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Professional for the provision of covered services under the CalOptima Cal MediConnect Program solely because Professional has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Professional represents and warrants that: (i) neither Professional nor any of its contracted Physicians, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Professional has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Professional knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Professional or any of its contracted Physicians, employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Professional agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Professional fails to comply with the above, CalOptima reserves the right to require Professional to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Professional shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Professional, Professional shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including, but not limited to, the following:

11.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 3.21 of the Contract.

11.1.2 An agreement to (i) Member financial protections in accordance with Section 9 of Article IV of Attachment B of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Professional, and (ii) safeguard Member privacy and confidentiality of Member health records.

11.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 3.18 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2 In addition to Section 11.1 of this Addendum 3, Professional shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Professional.

11.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and

diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 9.2 of Article IV of Attachment B of the Contract and Section 20 of this Addendum 3.

11.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7 An agreement that the medical provider assist the Professional and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.10 of the Contract in the event the subcontract is amended or terminated.

11.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under CalOptima Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Professional and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

11.2.10 An agreement to (i) participate and cooperate in equality improvement system as set forth in Section 3.17 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites.

12. Right of Inspection, Evaluation, and Audit of Records. Professional and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any other pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Professional and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 3.18 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Professional and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review, approve, and audit Professional's credentialing process on an ongoing basis.

15. Provider Terminations. In the event a provider is terminated for cause by Professional, Professional shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Professional terminates a provider for deficiencies in the quality of care provided, Professional shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 3.3 of the Contract, Professional agrees to assist CalOptima in the transfer of care of a Member. Professional shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Professional is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Professional agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Professional or Downstream Entity; (iii) the merger, reorganization, or consolidation of Professional or Downstream Entity, with another entity with respect to which Professional or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Professional or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Professional or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Professional agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Professional's or its Subcontractor's possession.

20. In addition to Section 9.2 of Article IV of Attachment B of the Contract, Professional acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

# ADDENDUM 4

**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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

| 1. Type of Federal Action: contract; grant; cooperative agreement; loan; loan guarantee; loan insurance | 2. Status of Federal Action: bid/offer/application; initial award; post-award | 3. Report Type: initial filing; material change. For Material Change Only: Year _____ quarter_______ date of last report |
|---|---|---|

| 4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known: | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known: |
|---|---|
| 6. Federal Department/Agency: | Federal Program Name/Description: CDFA Number, if applicable: |
| 8. Federal Action Number, if known: | 9. Award Amount, if known: |
| 10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s) | b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary) |
| Amount of Payment (check all that apply): $ actual planned | Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify: |
| Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value | |

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

| 16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure. | Signature: Print Name: Title: Telephone No.: Date: |
|---|---|

| **Federal Use Only** | Authorized for Local Reproduction Standard Form-LLL |
|---|---|

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

8. Consider Extension of the Professional Services Contracts for Clinics Associated with Providence St. Joseph Healthcare

**Contacts**

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

**Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Professional Services Contracts for Clinics associated with Providence St. Joseph Healthcare, through June 30, 2022, under the same terms and conditions

**Background/Discussion**

CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal (CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A)), OneCare, OneCare Connect (including CCN) and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board. Staff is requesting authority to extend the existing FFS Professional Services Contracts for Clinics associated Providence St. Joseph Healthcare, under the same terms and conditions, through June 30, 2022.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

**Fiscal Impact**

Management will include medical expenses related to the contract extensions in the upcoming Fiscal Year 2021-22 Operating Budget. To the extent there is any additional fiscal impact prior to the end of the fiscal year, such impact will be addressed in separate Board actions.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Back to Agenda

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Entities covered by this recommended action
2. Contract Template: Professional Services Contract for Fee-for-Service Clinics

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

Back to Agenda

## ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| La Amistad De Jose Family Health Center | 725 W La Veta Ave. Suite 260 | Orange | CA | 92868 |
| St Jude Neighborhood Health Centers | 3232 Topaz Lane | Fullerton | CA | 92831 |
| St Jude Neighborhood Health Centers | 731 S Highland Ave. | Fullerton | CA | 92832 |

**PROFESSIONAL SERVICES CONTRACT**

**GENERAL PROVISIONS**

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and _______________________ ("Professional"), with respect to the following:

**RECITALS**

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract through the Practitioners listed on Attachment C to CalOptima Members, as identified in Attachment A.

H. CalOptima and Professional desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

**ARTICLE 1**

**ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES**

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Professional's Practitioners who own, are employed by, or under contract with, Professional, and who will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of

such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: Cal MediConnect Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

## ARTICLE 2
## DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 “Approved Drug List” means CalOptima’s continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 “Assigned Members” means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima’s electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider’s participation in the program.

2.7 “Behavioral Health Services” means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 “Cal MediConnect” is a program to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima’s Cal MediConnect program. Cal MediConnect is also referred to as OneCare Connect.

2.9 “California Children’s Services (CCS)” means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 “California Children’s Services (CCS) Eligible Condition(s)”, means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 “California Children’s Services (CCS) Program” means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 “CalOptima Direct” or “COD” means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima’s Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 “CalOptima Direct—Administrative” or “COD-Administrative,” provides services to Members who reside outside of CalOptima’s service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 “CalOptima Policies” means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 “CalOptima Program(s)” means the Medi-Cal, Cal MediConnect, and PACE Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 “CalOptima's Regulators” means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 “Care Management Services” means (i) providing Physician Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member’s care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 “CCS Provider(s)” or “CCS-Paneled Provider(s)”, means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 "Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

2.38 "HealthCare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.39 "Health Risk Assessment" or "HRA" means the assessment tool which identifies a Member's primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 "Hospital Services" means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 "Hospitalist" means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 "Individualized Care Plan" or "ICP" means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

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2.43 "Interdisciplinary Care Team" or "ICT" means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 "Licenses" means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 "Medi-Cal Specialty Mental Health Services" mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 "Medical Necessity" or "Medically Necessary" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to

manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which

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treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

## ARTICLE 3
## FUNCTIONS AND DUTIES OF PROFESSIONAL

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall provide CalOptima with the following information, as applicable: (a) names of all officers of Professional's governing board; (b) names of all owners of Professional; (c) names of stockholders owning more than five percent (5%) of the stock issued by Professional; and (d) names of major creditors holding more than five percent (5%) of the debt of Professional. Professional shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Professional shall notify CalOptima immediately of any changes to the information included by Professional in the disclosure forms submitted to CalOptima.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 CalOptima QMI Program. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Professional. Professional agrees that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Professional further agrees to participate in all quality improvement studies including, but not limited to HEDIS data collection. Professional shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Professional Services (*e.g.,* medical necessity) and shall accept as final all decisions regarding disputes over Physician Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

Professional shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional 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. Professional and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national

origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional’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.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, 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.

Professional and its Downstream Entities 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 Professional’s commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional’s and its Subcontractors noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Professional may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional 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 Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any

advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Professional shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or

alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional 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. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a

significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima.

CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data."

## ARTICLE 4
## FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract.

## ARTICLE 5
## INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of

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such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

## ARTICLE 6
## RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For

purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

## ARTICLE 7
## TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2021. This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract."

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally- approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

c) Cal MediConnect program beneficiaries as described in this Section shall be paid at the Medicare rate for services covered under the Medicare benefit. Services for benefits not covered by Medicare but covered under Medi-Cal, the Medi-Cal rate as stated in the above paragraph "a" shall apply.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

7.10.1 Professional shall not furnish services under CalOptima's Cal MediConnect program unless and until CalOptima is authorized by DHCS and CMS to proceed with such program and CalOptima provides written notice to Professional of the commencement date of such services.

## ARTICLE 8
## GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

## ARTICLE 9
## MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings

against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

____________________________________
Name

____________________________________
Title

____________________________________
Address

____________________________________

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in

good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional 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.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

9.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.17 Debarment Certification. Professional agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) 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.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

9.17.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

## ARTICLE 10
## EXECUTION

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

| Professional | CalOptima |
|---|---|
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | Ladan Khamseh |
| Print Name | Print Name |
| ______________________ | Chief Operating Officer |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

# ATTACHMENT A

## CONTRACTED SERVICES

### ARTICLE 1
### CALOPTIMA PROGRAMS AND SERVICES

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Cal-MediConnect Program (Members Dually Eligible for Medicare and Medi-Cal Benefit) Includes Community Network

__X__ Medi-Cal Program (Community Network and COD Administrative)

__X__ PACE Program

1.2 Physician Services. Professional shall furnish:

__X__ Primary Care Provider Covered Services to eligible Members in the CalOptima program, who are assigned to Professional.

__X__ Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

### ARTICLE 2
### GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services

must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member's care. Professional shall forward the results of diagnostic procedures and consultations to Member's assigned PCP in a timely manner in order to ensure that the Member's care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima's Policies and for periodicity and content of pediatric

health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall

include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

**ATTACHMENT B**

**COMPENSATION**

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

## I. MEDI-CAL PROGRAM

**A. Primary Care Services**

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

   1.2. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

   1.3. NOT APPLICABLE TO THIS CONTRACT

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XXX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

   2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

**B. Specialist Services**

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. **Specialist Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

   1.2. NOT APPLICABLE TO THIS CONTRACT

   1.3. **Non Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. NOT APPLICABLE TO THIS CONTRACT

1.5. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.6. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

| CPT Code Range | Type of Service | Fee Schedule |
|---|---|---|
| **10000-69999** | **Surgical Range** | |
| **70000-79999** | **Radiology and Radiation Therapy Professional and Technical Components** | |
| **80000-89999** | **Lab and Pathology** | |
| **90000-99999** | **Professional Services** | |
| **HCPC Codes** | | |

1.6.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

1.6.2. Subject to approval by the CalOptima Board of Directors, the specialist rates identified in Section 1.6 shall be extended effective **July 1, 2018**.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## II. PACE PROGRAM

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or
2. **XX** of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.
3. Prior authorization rules apply for payment of services.
4. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
5. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   - 5.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   - 5.2 Professional shall utilize current payment codes and modifiers for Medicare.
   - 5.3. CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   - 5.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.
6. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

## III. CAL MEDICONNECT

For Covered Services provided to Cal MediConnect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of:

1. Billed charges, or XX of the Current Medicare Allowable Participating Provider Fee Schedule for locality 26.
2. Prior authorization rules apply for payment of services.
3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   - 4.1 "By Report & Unlisted" codes will be paid at XX of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   - 4.2 Professional shall utilize current payment codes and modifiers for Medicare.
   - 4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   - 4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.
   - 4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. NOT APPLICABLE TO THIS CONTRACT

8. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

9. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   9.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   9.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

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1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

9.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

9.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

9.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

**ATTACHMENT B-1**
**SUPPLEMENTAL COMPENSATION**
**PROPOSITION 56 FUNDING**

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services (both as defined in this Attachment B-1) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

   1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 increase in accordance with the Exhibit for the applicable State fiscal year attached to this Attachment, applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.

3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments for dates of service between July 1, 2017 and July 30, 2019 and beyond if so directed by DHCS.

4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

6. Notwithstanding other provisions of this Attachment B-1, effective July 1, 2020, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

**ATTACHMENT B-1, Exhibit 1**
**SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |

**ATTACHMENT B-1, Exhibit 2**

**SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |
| 99381 | Initial Comprehensive Preventive Med E&M (<1-year-old) | |
| 99382 | Initial Comprehensive Preventive Med E&M (1-4 Years old | |
| 99383 | Initial Comprehensive Preventive Med E&M (5-11 years old) | |
| 99384 | Initial Comprehensive Preventive Med E&M (12-17 Years old) | |
| 99385 | Initial Comprehensive Preventive Med E&M (18-39 Years old) | |
| 99391 | Periodic comprehensive preventive med E&M (<1-year-old) | |
| 99392 | Periodic comprehensive preventive med E&M (1-4 years old) | |
| 99393 | Periodic comprehensive preventive med E&M (5-11 years old) | |
| 99394 | Periodic comprehensive preventive med E&M (12-17 years old) | |
| 99395 | Periodic comprehensive preventive med E&M (18-19 years old) | |

## ATTACHMENT C

### PROFESSIONAL / PRACTITIONER

Professional's Name ______________________________________________

Address ______________________________________________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________________________________

Note: The email address will be used to send communication electronically when applicable. Please indicate the appropriate contact's email address.

Date ______________________

This Attachment may be amended from time to time, and shall incorporate Practitioners who (i.) own, are employed by, or under contract with, Professional, including locum tenens; and (ii.) will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima requirements and credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least 30 days prior to the effective date of such addition or deletion. CalOptima shall maintain the roster of Professional's Practitioners with the applicable effective date of addition and/or deletion. Please attach separate list with the information below, if necessary.

**ATTACHMENT D**
**SPECIAL PROVISIONS**

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## ATTACHMENT E

## DISCLOSURE FORM

____________________________________________
Name of Provider

The undersigned hereby certifies that the following information regarding

__________________________________________ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

______________________________________________________________________

______________________________________________________________________

Co-Owner(s):

______________________________________________________________________

______________________________________________________________________

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

______________________________________________________________________

______________________________________________________________________

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

______________________________________________________________________

______________________________________________________________________

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

______________________________________________________________________

______________________________________________________________________

Dated: __________________________ Signature: ____________________________________

Name: ____________________________________
(Please type or print)

Title: ____________________________________
(Please type or print)

**ADDENDUM 1**
**MEDI-CAL PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Programs: These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail. For purpose of this Addendum 1, "State Contract" means the written agreement between CalOptima and DHCS pursuant to which CalOptima is obligated to arrange and pay for the provision of Medi-Cal Covered Services to Members in Orange County, California.

1. Professional and other Providers of Services. Upon request, Professional shall provide CalOptima with a list of approved Practitioners providing Covered Services, together with any information requested by CalOptima for credentialing and/or the administration of its QMI Program. Professional shall, as warranted, immediately restrict or suspend Practitioners from providing Physician Services to Members when: (i) the Practitioner ceases to meet Minimum Provider Standards and/or other licensing/certification requirements or other professional standards described in this Contract; or (ii) CalOptima reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the applicable Practitioner that does or could adversely affect the health or safety of Members. Professional shall immediately notify CalOptima of any of Professional's Practitioner(s) who ceases to meet Minimum Provider Standards or licensing/certification requirements and Professional's action.

2. Emergency Services. Professional shall comply with all applicable State and Federal laws and regulations, as well as State Contract, Exhibit A, Attachment 8, Provision 13, governing the provisions and payment of Emergency Services including, without limitation, the following requirements:

    2.1 Professional shall furnish Emergency Services on a twenty four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Professional for Emergency services without Prior Authorization.

    2.2 Payment will not be denied where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 2.28.

    2.3 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

    2.4 The attending emergency Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

    2.5 Professional shall refer any Community Network Member not assigned to Professional back to the assigned Primary Care Provider, and shall facilitate the transfer of any applicable records to such Physician.

    2.6 Professional and Professional's Practitioners shall be and remain during the period of this Contract duly licensed to practice in their profession in the State of California or in the state in which Professional will be providing Physician Services to Members. Professional is currently in good standing, and at all times during the term of this Contract shall maintain good standing, with the following:

        2.6.1 all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

        2.6.2 certification under Medi-Cal and Medicare; and

        2.6.3 Board certification to the extent required by CalOptima Policies.

3. Hospital Admissions. Professional may not admit a Member to a hospital on a non-emergency basis without first receiving Prior Authorization from CalOptima's UM Department. Professional shall coordinate care with Hospitalists for Member hospital admissions and provide history, medications, referrals and previous work-up information.

4. Admissions to Long Term Care Facility. Professional shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Professional shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long-term care, Professional shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

5. Confidentiality of Sensitive Services Information. If a Professional supplies Sensitive Services, including Family Planning Services, Professional shall comply with State confidentiality laws, regulations and other requirements relating to Members' Family Planning information and records and Professional acknowledges that he or she is solely responsible for developing and implementing Policies and Procedures to ensure compliance with such confidentiality requirements. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Professional shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

6. Linguistic and Cultural Sensitivity Services. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its Policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level. Professional shall comply with the language assistance standards developed pursuant to Health & Safety Code section 1367.01.

7. Provision of Interpreters. Professional shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract and CalOptima Policies. Professional shall ensure provision of interpreter services to Members at all provider sites.

   Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Professional shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

   The provision of interpreter services required by this section may be undertaken in accordance with the Provider Manual and CalOptima Policy.

8. Overpayments and CalOptima Right to Recover. Professional has an obligation to report any overpayment identified by Professional, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Professional, or of receipt of notice of an overpayment identified by CalOptima. Professional acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Professional, CalOptima shall have the right to recover such amounts from Professional by recoupment or offset from current or future amounts due from CalOptima to Professional, after giving Professional notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Professional to CalOptima, including, but not limited to, amounts due because of:

8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

8.3 Unpaid Conlon reimbursements owed by Professional to a Member.

8.4 Payments made for services provided by a Professional that has entered into a private contract with a Medicare beneficiary for Covered Services.

9. Professional Subcontracts. If the Professional is an individual sole practitioner, the Professional shall not subcontract for the provision of Covered Services to Members.

10. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. CalOptima will reimburse Professional at the current CalOptima Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

11. Electronic Transactions. Professional agrees to engage in exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions.

12. Records Retention. Professional and its Subcontractors shall maintain and retain all records of all items and services provided to Members: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Professional's or Subcontractor's place of business or at such mutually agreeable location in California; and (c) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Physician's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

13. Access to Books and Records.

13.1 Professional agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and the State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Professional's place of business or at such other mutually agreeable location in California, (c) in a form maintained in accordance with the general

standards applicable to such book or record keeping, (d) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, and (e) including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Professional shall provide access to all security areas and shall provide reasonable cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Professional at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

13.2 Through the end of the records retention period specified in Section 13.1, above, Professional shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Professional pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 13.1, above, Professional shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Professional's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Professional's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations, as well as requirements of DHCS and this Contract.

13.3 Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of Professional's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Professional, Subcontractor, and provider facilities, management systems and procedures, and books and records, as the Director of DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Professional. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Professional will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Professional or the Subcontractor(s).

13.4 The provisions of this Section 13 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

14. Form of Records. Professional's books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

15. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Professional site.

16. Downstream Contracts. In the event that Professional is allowed to Subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS. Professional shall ensure that all Subcontracts are in writing and require that the Professional and its Subcontractors:

    16.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

    16.2 Retain such books and all records and documents through the end of the records retention period specified in Section 13.1

17. Assignment and Delegation. Professional agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Professional or Subcontractor; (iii) the merger, reorganization, or consolidation of Professional or Subcontractor with another entity with respect to which Professional or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Professional or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Professional or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

19. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional related to this Contract.

19.1 Professional further agrees to timely gather, preserve, and provide to DHCS any records in the Professional's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

20. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

21. LEFT BLANK INTENTIONALLY

22. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

23. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Providers 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 Professional, its employees, agents, or Providers as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Providers shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Providers shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional:

23.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

23.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

23.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

23.4 will, at the termination of this Contract, return all such information to CalOptima that Professional is not legally or contractually required to retain and make available, and maintain all other such information according to written procedures sent to the Professional by CalOptima for this purpose.

24. DHCS Directions. If required by DHCS, Professional shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

25. Additional Subcontracting Requirements. Professional shall require all Subcontractors that relate to the provision of Medi-Cal Covered Services to Members pursuant to this Contract include the following:

25.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

25.2 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

25.3 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

25.4 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 1, and (b) to notify DHCS in the manner provided in Section 7.10 of the Contract in the event the Subcontract is amended or terminated

25.5 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Section 3.38 of the Contract and Section 26 of this Addendum 1, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 19 and 19.1 of this Addendum 1.

25.6 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 13 of this Addendum 1.

25.7 An agreement to maintain and make available to DHCS, CalOptima, and/or Professional, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Sections 16.1 to 16.2 of this Addendum 1.

25.8 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies) and the requirements set forth in Section 27 of this Addendum 1.

25.9 An agreement to assist Professional and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 29 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section IV.9 of Attachment B of the Contract.

25.11 An agreement to the requirements for cultural and linguistic sensitivity and the provision of interpreter services to be provided as set forth in Sections 6 and 7 of this Addendum 1.

25.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal Members, as provided in CalOptima Policies relative to the Medi-Cal program, and excluding any contract disputes between Professional and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

25.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 3.17 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima, and/or Professional determines that the Subcontractor has not performed satisfactorily.

25.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 32 of this Addendum 1 and Section 6.5.3 of the Contract.

25.15 An agreement by the Professional to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.6 of the Contract.

25.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 to 6.3 of the Contract and Sections 12 to 13 of this Addendum 1.

25.17 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

26. Professional shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

27. Professional shall comply with (a) DHCS Medi-Cal Provider Bulletins and Manuals, (b) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and (c) all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

28. Professional shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by Professional pursuant to the Contract.

29. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Professional shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, and the continuity, to the extent possible, of Member-Provider relationships. Cost of reproduction shall be borne by DHCS and CalOptima as applicable.

29.1 Professional agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

30. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

31. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

32. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with the Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use it as the Professional is able for the purpose of Member care coordination.

**ADDENDUM 2**
**PACE PROGRAM REQUIREMENTS**

The terms and requirements of this Addendum 2 shall apply for services provided by Professional to Members who are enrolled in the CalOptima PACE program only. These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail.

1. State Approval and Termination.

1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

1.2 Amendments to this Contract and amendments to any subcontract agreements between Professional and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Professional of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Professional's Responsibilities applicable to providing services to CalOptima PACE Members. Professional shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE Members, Professional agrees to do the following:

2.1 Professional shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

2.2 Duties Related to Professional's Position. Professional shall perform all the duties related to its position, as specified in this Contract.

2.3 Services Authorized. Professional shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Professional shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Professional will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Professional pursuant to this Contract.

2.6 Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.7 Coverage of Non-Network Providers. Professional agrees that should arrangements be made by Professional with another physician/provider who is not under contract with CalOptima to provider Covered Services required under this Contract, such physician/provider shall (a) accept Professional's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Professional's office, unless Professional has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.8 Participant Bill of Rights. Professional shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Professional.

2.9 Provision of Direct Care Services to PACE Participants. Professional hereby represents and warrants that Professional and all employees of Professional providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Professional agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Professional or any employee of Professional providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.9.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2. 9.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Professional furnishes;

2. 9.3 Have verified current certifications or licenses for their respective positions;

2. 9.4 Have not been excluded from participation in Medicare, or Medi-Cal;

2. 9.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2. 9.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2. 9.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2. 9.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Professional and PACE.

3. Records Retention. Professional and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving

matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Professional's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Professional and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Professional's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Professional shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Professional and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Professional may possess in order to verify Professional's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Practitioner or Subcontractor site.

6. Downstream Contracts. In the event that Professional is allowed to subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Professional, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions); (ii) the change

of more than twenty-five percent (25%) of the directors or trustees of Professional; (iii) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity; and/or (iv) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Professional, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For

the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Professional may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional or its Subcontractors, Professional:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

13. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

## ADDENDUM 3
## CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Professional shall provide services or perform other activity pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS,
2. Professional shall (i) safeguard Member privacy and confidentiality of Member health records, (ii) comply with all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Professional and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Professional shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Professional shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Professional shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Professional acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with hospital actions required to comply with EMTALA.
7. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
8. Professional shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
9. Professional shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Professional. Professional may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such Professional is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Professional for the provision of covered services under the CalOptima Cal MediConnect Program solely because Professional has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Professional represents and warrants that: (i) neither Professional nor any of its contracted Physicians, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Professional has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Professional knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Professional or any of its contracted Physicians, employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Professional agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Professional fails to comply with the above, CalOptima reserves the right to require Professional to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Professional shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Professional, Professional shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including, but not limited to, the following:

11.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 3.21 of the Contract.

11.1.2 An agreement to (i) Member financial protections in accordance with Section 9 of Article IV of Attachment B of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Professional, and (ii) safeguard Member privacy and confidentiality of Member health records.

11.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 3.18 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2 In addition to Section 11.1 of this Addendum 3, Professional shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Professional.

11.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and

diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 9.2 of Article IV of Attachment B of the Contract and Section 20 of this Addendum 3.

11.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7 An agreement that the medical provider assist the Professional and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.10 of the Contract in the event the subcontract is amended or terminated.

11.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under CalOptima Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Professional and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

11.2.10 An agreement to (i) participate and cooperate in equality improvement system as set forth in Section 3.17 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites.

12. Right of Inspection, Evaluation, and Audit of Records. Professional and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any other pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Professional and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 3.18 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Professional and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review, approve, and audit Professional's credentialing process on an ongoing basis.

15. Provider Terminations. In the event a provider is terminated for cause by Professional, Professional shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Professional terminates a provider for deficiencies in the quality of care provided, Professional shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 3.3 of the Contract, Professional agrees to assist CalOptima in the transfer of care of a Member. Professional shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Professional is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Professional agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Professional or Downstream Entity; (iii) the merger, reorganization, or consolidation of Professional or Downstream Entity, with another entity with respect to which Professional or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Professional or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Professional or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Professional agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Professional's or its Subcontractor's possession.

20. In addition to Section 9.2 of Article IV of Attachment B of the Contract, Professional acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

# ADDENDUM 4

**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

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

| 1. Type of Federal Action: | 2. Status of Federal Action: | 3. Report Type: |
|---|---|---|
| contract<br>grant<br>cooperative agreement<br>loan<br>loan guarantee<br>loan insurance | bid/offer/application<br>initial award<br>post-award | initial filing<br>material change<br>For Material Change Only:<br>Year _____ quarter_______<br>date of last report |

| | |
|---|---|
| 4. Name and Address of Reporting Entity:<br>Prime Subawardee<br>Tier , if known:<br><br>Congressional District, If known: | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:<br><br>Congressional District, If known: |
| 6. Federal Department/Agency: | Federal Program Name/Description:<br><br>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):<br><br>(attach Continuation Sheets(s) | b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):<br><br>SF-LLL-A, If necessary) |
| Amount of Payment (check all that apply):<br>$ actual planned<br>Form of Payment (check all that apply):<br>a. cash<br>b. in-kind, specify: Nature<br>Value | Type of Payment (check all that apply):<br>a. retainer<br>b. one-time fee<br>c. commission<br>d. contingent fee<br>e. deferred<br>f. other, specify: |

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

| | |
|---|---|
| 16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure. | Signature:<br>Print Name:<br>Title:<br>Telephone No.: Date: |

| **Federal Use Only** | Authorized for Local Reproduction<br>Standard Form-LLL |
|---|---|

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks “Subawardee,” then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., “RFP-DE-90401.”

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

9. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts Affiliated with Providence St. Joseph Heritage Healthcare and its Affiliates

**Contacts**

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

**Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend Primary Care and Specialist Physician fee-for-service (FFS) Professional Services Contracts affiliated with the Providence St. Joseph Heritage Healthcare and its Affiliates through June 30, 2022, under the same terms and conditions

**Background/Discussion**

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care and Specialist services on a fee-for-service (FFS) basis to Medi-Cal (CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A)), OneCare Connect (including CCN) and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board. Staff is requesting authority to extend the Medi-Cal, OneCare Connect and PACE FFS Primary Care and Specialist Professional Services Contracts affiliated with Providence St. Joseph Heritage Healthcare through June 30, 2022.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

**Fiscal Impact**

Management will include medical expenses related to the contract extensions in the upcoming Fiscal Year 2021-22 Operating Budget. To the extent there is any additional fiscal impact prior to the end of the fiscal year, such impact will be addressed in separate Board actions.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Contract Template: Primary Care and Specialist Fee-for-Service Professional Services Contract

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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# PROFESSIONAL SERVICES CONTRACT

## GENERAL PROVISIONS

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and _______________________ ("Professional"), with respect to the following:

## RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract through the Practitioners listed on Attachment C to CalOptima Members, as identified in Attachment A.

H. CalOptima and Professional desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

## ARTICLE 1

## ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Professional's Practitioners who own, are employed by, or under contract with, Professional, and who will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of

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such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: Cal MediConnect Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

## ARTICLE 2
## DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 "Assigned Members" means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima's electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider's participation in the program.

2.7 "Behavioral Health Services" means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 "Cal MediConnect" is a program to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program. Cal MediConnect is also referred to as OneCare Connect.

2.9 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 "CalOptima Direct" or "COD" means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 "CalOptima Direct—Administrative" or "COD-Administrative," provides services to Members who reside outside of CalOptima's service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 "CalOptima Policies" means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 "CalOptima Program(s)" means the Medi-Cal, Cal MediConnect, and PACE Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 "Care Management Services" means (i) providing Physician Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member's care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 "CCS Provider(s)" or "CCS-Paneled Provider(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 "Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

2.38 "HealthCare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.39 "Health Risk Assessment" or "HRA" means the assessment tool which identifies a Member's primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 "Hospital Services" means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 "Hospitalist" means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 "Individualized Care Plan" or "ICP" means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

2.43 "Interdisciplinary Care Team" or "ICT" means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 "Licenses" means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 "Medi-Cal Specialty Mental Health Services" mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 "Medical Necessity" or "Medically Necessary" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to

manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which

treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

## ARTICLE 3
## FUNCTIONS AND DUTIES OF PROFESSIONAL

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall provide CalOptima with the following information, as applicable: (a) names of all officers of Professional's governing board; (b) names of all owners of Professional; (c) names of stockholders owning more than five percent (5%) of the stock issued by Professional; and (d) names of major creditors holding more than five percent (5%) of the debt of Professional. Professional shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Professional shall notify CalOptima immediately of any changes to the information included by Professional in the disclosure forms submitted to CalOptima.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 CalOptima QMI Program. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Professional. Professional agrees that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Professional further agrees to participate in all quality improvement studies including, but not limited to HEDIS data collection. Professional shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Professional Services (*e.g.,* medical necessity) and shall accept as final all decisions regarding disputes over Physician Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

Professional shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional 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. Professional and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national

origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional'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.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, 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.

Professional and its Downstream Entities 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 Professional's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional's and its Subcontractors noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Professional may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional 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 Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any

advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Professional shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or

alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional 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. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a

significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima.

CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data."

## ARTICLE 4
## FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract.

## ARTICLE 5
## INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of

such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

## ARTICLE 6
## RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For

purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

**ARTICLE 7**
**TERM AND TERMINATION**

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2021. This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract."

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally- approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

c) Cal MediConnect program beneficiaries as described in this Section shall be paid at the Medicare rate for services covered under the Medicare benefit. Services for benefits not covered by Medicare but covered under Medi-Cal, the Medi-Cal rate as stated in the above paragraph "a" shall apply.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

7.10.1 Professional shall not furnish services under CalOptima's Cal MediConnect program unless and until CalOptima is authorized by DHCS and CMS to proceed with such program and CalOptima provides written notice to Professional of the commencement date of such services.

## ARTICLE 8
## GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

## ARTICLE 9
## MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings

against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

______________________________________
Name

______________________________________
Title

______________________________________
Address

______________________________________

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in

good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional 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.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

9.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.17 Debarment Certification. Professional agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) 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.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

9.17.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

**ARTICLE 10**
**EXECUTION**

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

| Professional | CalOptima |
|---|---|
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | Ladan Khamseh |
| Print Name | Print Name |
| ______________________ | Chief Operating Officer |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

**ATTACHMENT A**

**CONTRACTED SERVICES**

**ARTICLE 1**
**CALOPTIMA PROGRAMS AND SERVICES**

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Cal-MediConnect Program (Members Dually Eligible for Medicare and Medi-Cal Benefit) Includes Community Network

__X__ Medi-Cal Program (Community Network and COD Administrative)

__X__ PACE Program

1.2 Physician Services. Professional shall furnish:

__X__ Primary Care Provider Covered Services to eligible Members in the CalOptima program, who are assigned to Professional.

__X__ Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

**ARTICLE 2**
**GENERAL RESPONSIBILITIES**

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services

must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member’s medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members’ care and coordinating utilization of services to facilitate the return of Member’s care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member’s care. Professional shall forward the results of diagnostic procedures and consultations to Member’s assigned PCP in a timely manner in order to ensure that the Member’s care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima’s Policies and for periodicity and content of pediatric

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health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall

include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

## ATTACHMENT B

## COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

## I. MEDI-CAL PROGRAM

### A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

   1.2. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

   1.3. NOT APPLICABLE TO THIS CONTRACT

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XXX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

   2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

### B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. **Specialist Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

   1.2. NOT APPLICABLE TO THIS CONTRACT

   1.3. **Non Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. NOT APPLICABLE TO THIS CONTRACT

1.5. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.6. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

| CPT Code Range | Type of Service | Fee Schedule |
|---|---|---|
| **10000-69999** | **Surgical Range** | |
| **70000-79999** | **Radiology and Radiation Therapy Professional and Technical Components** | |
| **80000-89999** | **Lab and Pathology** | |
| **90000-99999** | **Professional Services** | |
| **HCPC Codes** | | |

1.6.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

1.6.2. Subject to approval by the CalOptima Board of Directors, the specialist rates identified in Section 1.6 shall be extended effective **July 1, 2018**.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## II. PACE PROGRAM

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or
2. **XX** of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.
3. Prior authorization rules apply for payment of services.
4. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
5. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   - 5.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   - 5.2 Professional shall utilize current payment codes and modifiers for Medicare.
   - 5.3. CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   - 5.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.
6. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

## III. CAL MEDICONNECT

For Covered Services provided to Cal MediConnect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of:

1. Billed charges, or XX of the Current Medicare Allowable Participating Provider Fee Schedule for locality 26.
2. Prior authorization rules apply for payment of services.
3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:
   - 4.1 "By Report & Unlisted" codes will be paid at XX of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.
   - 4.2 Professional shall utilize current payment codes and modifiers for Medicare.
   - 4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.
   - 4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.
   - 4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

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## IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. NOT APPLICABLE TO THIS CONTRACT

8. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

9. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   9.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   9.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

9.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

9.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

9.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

## ATTACHMENT B-1
## SUPPLEMENTAL COMPENSATION
## PROPOSITION 56 FUNDING

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services (both as defined in this Attachment B-1) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

    1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 increase in accordance with the Exhibit for the applicable State fiscal year attached to this Attachment, applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.

3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments for dates of service between July 1, 2017 and July 30, 2019 and beyond if so directed by DHCS.

4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

6. Notwithstanding other provisions of this Attachment B-1, effective July 1, 2020, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

**ATTACHMENT B-1, Exhibit 1**
**SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |

**ATTACHMENT B-1, Exhibit 2**
**SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |
| 99381 | Initial Comprehensive Preventive Med E&M (<1-year-old) | |
| 99382 | Initial Comprehensive Preventive Med E&M (1-4 Years old | |
| 99383 | Initial Comprehensive Preventive Med E&M (5-11 years old) | |
| 99384 | Initial Comprehensive Preventive Med E&M (12-17 Years old) | |
| 99385 | Initial Comprehensive Preventive Med E&M (18-39 Years old) | |
| 99391 | Periodic comprehensive preventive med E&M (<1-year-old) | |
| 99392 | Periodic comprehensive preventive med E&M (1-4 years old) | |
| 99393 | Periodic comprehensive preventive med E&M (5-11 years old) | |
| 99394 | Periodic comprehensive preventive med E&M (12-17 years old) | |
| 99395 | Periodic comprehensive preventive med E&M (18-19 years old) | |

# ATTACHMENT C

## PROFESSIONAL / PRACTITIONER

Professional's Name ________________________________________

Address ________________________________________

Phone Number ____________________ Fax Number ____________________

Email Address ________________________________________

Note: The email address will be used to send communication electronically when applicable. Please indicate the appropriate contact's email address.

Date __________________________

This Attachment may be amended from time to time, and shall incorporate Practitioners who (i.) own, are employed by, or under contract with, Professional, including locum tenens; and (ii.) will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima requirements and credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least 30 days prior to the effective date of such addition or deletion. CalOptima shall maintain the roster of Professional's Practitioners with the applicable effective date of addition and/or deletion. Please attach separate list with the information below, if necessary.

**ATTACHMENT D**
**SPECIAL PROVISIONS**

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## ATTACHMENT E

## DISCLOSURE FORM

_____________________________________________

Name of Provider

The undersigned hereby certifies that the following information regarding

_____________________________________________ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____________________________________________

_____________________________________________

Co-Owner(s):

_____________________________________________

_____________________________________________

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____________________________________________

_____________________________________________

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____________________________________________

_____________________________________________

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____________________________________________

_____________________________________________

Dated: ___________________________

Signature: _____________________________________

Name: _____________________________________
(Please type or print)

Title: _____________________________________
(Please type or print)

## ADDENDUM 1
## MEDI-CAL PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Programs: These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail. For purpose of this Addendum 1, "State Contract" means the written agreement between CalOptima and DHCS pursuant to which CalOptima is obligated to arrange and pay for the provision of Medi-Cal Covered Services to Members in Orange County, California.

1. Professional and other Providers of Services. Upon request, Professional shall provide CalOptima with a list of approved Practitioners providing Covered Services, together with any information requested by CalOptima for credentialing and/or the administration of its QMI Program. Professional shall, as warranted, immediately restrict or suspend Practitioners from providing Physician Services to Members when: (i) the Practitioner ceases to meet Minimum Provider Standards and/or other licensing/certification requirements or other professional standards described in this Contract; or (ii) CalOptima reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the applicable Practitioner that does or could adversely affect the health or safety of Members. Professional shall immediately notify CalOptima of any of Professional's Practitioner(s) who ceases to meet Minimum Provider Standards or licensing/certification requirements and Professional's action.

2. Emergency Services. Professional shall comply with all applicable State and Federal laws and regulations, as well as State Contract, Exhibit A, Attachment 8, Provision 13, governing the provisions and payment of Emergency Services including, without limitation, the following requirements:

   2.1 Professional shall furnish Emergency Services on a twenty four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Professional for Emergency services without Prior Authorization.

   2.2 Payment will not be denied where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 2.28.

   2.3 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

   2.4 The attending emergency Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

   2.5 Professional shall refer any Community Network Member not assigned to Professional back to the assigned Primary Care Provider, and shall facilitate the transfer of any applicable records to such Physician.

   2.6 Professional and Professional's Practitioners shall be and remain during the period of this Contract duly licensed to practice in their profession in the State of California or in the state in which Professional will be providing Physician Services to Members. Professional is currently in good standing, and at all times during the term of this Contract shall maintain good standing, with the following:

      2.6.1 all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

      2.6.2 certification under Medi-Cal and Medicare; and

      2.6.3 Board certification to the extent required by CalOptima Policies.

3. Hospital Admissions. Professional may not admit a Member to a hospital on a non-emergency basis without first receiving Prior Authorization from CalOptima's UM Department. Professional shall coordinate care with Hospitalists for Member hospital admissions and provide history, medications, referrals and previous work-up information.

4. Admissions to Long Term Care Facility. Professional shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Professional shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long-term care, Professional shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

5. Confidentiality of Sensitive Services Information. If a Professional supplies Sensitive Services, including Family Planning Services, Professional shall comply with State confidentiality laws, regulations and other requirements relating to Members' Family Planning information and records and Professional acknowledges that he or she is solely responsible for developing and implementing Policies and Procedures to ensure compliance with such confidentiality requirements. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Professional shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

6. Linguistic and Cultural Sensitivity Services. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its Policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level. Professional shall comply with the language assistance standards developed pursuant to Health & Safety Code section 1367.01.

7. Provision of Interpreters. Professional shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract and CalOptima Policies. Professional shall ensure provision of interpreter services to Members at all provider sites.

   Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Professional shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

   The provision of interpreter services required by this section may be undertaken in accordance with the Provider Manual and CalOptima Policy.

8. Overpayments and CalOptima Right to Recover. Professional has an obligation to report any overpayment identified by Professional, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Professional, or of receipt of notice of an overpayment identified by CalOptima. Professional acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Professional, CalOptima shall have the right to recover such amounts from Professional by recoupment or offset from current or future amounts due from CalOptima to Professional, after giving Professional notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Professional to CalOptima, including, but not limited to, amounts due because of:

8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

8.3 Unpaid Conlon reimbursements owed by Professional to a Member.

8.4 Payments made for services provided by a Professional that has entered into a private contract with a Medicare beneficiary for Covered Services.

9. Professional Subcontracts. If the Professional is an individual sole practitioner, the Professional shall not subcontract for the provision of Covered Services to Members.

10. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. CalOptima will reimburse Professional at the current CalOptima Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

11. Electronic Transactions. Professional agrees to engage in exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions.

12. Records Retention. Professional and its Subcontractors shall maintain and retain all records of all items and services provided to Members: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Professional's or Subcontractor's place of business or at such mutually agreeable location in California; and (c) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Physician's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

13. Access to Books and Records.

13.1 Professional agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and the State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Professional's place of business or at such other mutually agreeable location in California, (c) in a form maintained in accordance with the general

standards applicable to such book or record keeping, (d) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, and (e) including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Professional shall provide access to all security areas and shall provide reasonable cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Professional at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

13.2 Through the end of the records retention period specified in Section 13.1, above, Professional shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Professional pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 13.1, above, Professional shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Professional's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Professional's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations, as well as requirements of DHCS and this Contract.

13.3 Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of Professional's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Professional, Subcontractor, and provider facilities, management systems and procedures, and books and records, as the Director of DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Professional. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Professional will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Professional or the Subcontractor(s).

13.4 The provisions of this Section 13 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

14. Form of Records. Professional's books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

15. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Professional site.

16. Downstream Contracts. In the event that Professional is allowed to Subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS. Professional shall ensure that all Subcontracts are in writing and require that the Professional and its Subcontractors:

    16.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

    16.2 Retain such books and all records and documents through the end of the records retention period specified in Section 13.1

17. Assignment and Delegation. Professional agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Professional or Subcontractor; (iii) the merger, reorganization, or consolidation of Professional or Subcontractor with another entity with respect to which Professional or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Professional or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Professional or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

19. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional related to this Contract.

19.1 Professional further agrees to timely gather, preserve, and provide to DHCS any records in the Professional's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

20. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

21. LEFT BLANK INTENTIONALLY

22. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

23. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Providers 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 Professional, its employees, agents, or Providers as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Providers shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Providers shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional:

23.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

23.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

23.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

23.4 will, at the termination of this Contract, return all such information to CalOptima that Professional is not legally or contractually required to retain and make available, and maintain all other such information according to written procedures sent to the Professional by CalOptima for this purpose.

24. DHCS Directions. If required by DHCS, Professional shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

25. Additional Subcontracting Requirements. Professional shall require all Subcontractors that relate to the provision of Medi-Cal Covered Services to Members pursuant to this Contract include the following:

25.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

25.2 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

25.3 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

25.4 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 1, and (b) to notify DHCS in the manner provided in Section 7.10 of the Contract in the event the Subcontract is amended or terminated

25.5 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Section 3.38 of the Contract and Section 26 of this Addendum 1, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 19 and 19.1 of this Addendum 1.

25.6 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 13 of this Addendum 1.

25.7 An agreement to maintain and make available to DHCS, CalOptima, and/or Professional, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Sections 16.1 to 16.2 of this Addendum 1.

25.8 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies) and the requirements set forth in Section 27 of this Addendum 1.

25.9 An agreement to assist Professional and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 29 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section IV.9 of Attachment B of the Contract.

25.11 An agreement to the requirements for cultural and linguistic sensitivity and the provision of interpreter services to be provided as set forth in Sections 6 and 7 of this Addendum 1.

25.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal Members, as provided in CalOptima Policies relative to the Medi-Cal program, and excluding any contract disputes between Professional and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

25.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 3.17 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima, and/or Professional determines that the Subcontractor has not performed satisfactorily.

25.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 32 of this Addendum 1 and Section 6.5.3 of the Contract.

25.15 An agreement by the Professional to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.6 of the Contract.

25.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 to 6.3 of the Contract and Sections 12 to 13 of this Addendum 1.

25.17 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

26. Professional shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

27. Professional shall comply with (a) DHCS Medi-Cal Provider Bulletins and Manuals, (b) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and (c) all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

28. Professional shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by Professional pursuant to the Contract.

29. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Professional shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, and the continuity, to the extent possible, of Member-Provider relationships. Cost of reproduction shall be borne by DHCS and CalOptima as applicable.

29.1 Professional agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

30. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

31. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

32. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with the Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use it as the Professional is able for the purpose of Member care coordination.

**ADDENDUM 2**
**PACE PROGRAM REQUIREMENTS**

The terms and requirements of this Addendum 2 shall apply for services provided by Professional to Members who are enrolled in the CalOptima PACE program only. These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail.

1. State Approval and Termination.

1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

1.2 Amendments to this Contract and amendments to any subcontract agreements between Professional and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Professional of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Professional's Responsibilities applicable to providing services to CalOptima PACE Members. Professional shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE Members, Professional agrees to do the following:

2.1 Professional shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

2.2 Duties Related to Professional's Position. Professional shall perform all the duties related to its position, as specified in this Contract.

2.3 Services Authorized. Professional shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Professional shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Professional will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Professional pursuant to this Contract.

2.6 Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.7 Coverage of Non-Network Providers. Professional agrees that should arrangements be made by Professional with another physician/provider who is not under contract with CalOptima to provider Covered Services required under this Contract, such physician/provider shall (a) accept Professional's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Professional's office, unless Professional has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.8 Participant Bill of Rights. Professional shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Professional.

2.9 Provision of Direct Care Services to PACE Participants. Professional hereby represents and warrants that Professional and all employees of Professional providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Professional agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Professional or any employee of Professional providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.9.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2. 9.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Professional furnishes;

2. 9.3 Have verified current certifications or licenses for their respective positions;

2. 9.4 Have not been excluded from participation in Medicare, or Medi-Cal;

2. 9.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2. 9.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2. 9.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2. 9.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Professional and PACE.

3. Records Retention. Professional and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving

matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Professional's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Professional and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Professional's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Professional shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Professional and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Professional may possess in order to verify Professional's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Practitioner or Subcontractor site.

6. Downstream Contracts. In the event that Professional is allowed to subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Professional, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions); (ii) the change

of more than twenty-five percent (25%) of the directors or trustees of Professional; (iii) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity; and/or (iv) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Professional, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For

the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Professional may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional or its Subcontractors, Professional:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

13. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

**ADDENDUM 3**
**CAL MEDICONNECT PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Professional shall provide services or perform other activity pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS,
2. Professional shall (i) safeguard Member privacy and confidentiality of Member health records, (ii) comply with all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Professional and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Professional shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Professional shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Professional shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Professional acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with hospital actions required to comply with EMTALA.
7. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
8. Professional shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
9. Professional shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Professional. Professional may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such Professional is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Professional for the provision of covered services under the CalOptima Cal MediConnect Program solely because Professional has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Professional represents and warrants that: (i) neither Professional nor any of its contracted Physicians, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Professional has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Professional knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Professional or any of its contracted Physicians, employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Professional agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Professional fails to comply with the above, CalOptima reserves the right to require Professional to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Professional shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Professional, Professional shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including, but not limited to, the following:

11.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 3.21 of the Contract.

11.1.2 An agreement to (i) Member financial protections in accordance with Section 9 of Article IV of Attachment B of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Professional, and (ii) safeguard Member privacy and confidentiality of Member health records.

11.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 3.18 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2 In addition to Section 11.1 of this Addendum 3, Professional shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Professional.

11.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and

diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 9.2 of Article IV of Attachment B of the Contract and Section 20 of this Addendum 3.

11.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7 An agreement that the medical provider assist the Professional and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.10 of the Contract in the event the subcontract is amended or terminated.

11.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under CalOptima Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Professional and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

11.2.10 An agreement to (i) participate and cooperate in equality improvement system as set forth in Section 3.17 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites.

12. Right of Inspection, Evaluation, and Audit of Records. Professional and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any other pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Professional and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 3.18 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Professional and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review, approve, and audit Professional's credentialing process on an ongoing basis.

15. Provider Terminations. In the event a provider is terminated for cause by Professional, Professional shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Professional terminates a provider for deficiencies in the quality of care provided, Professional shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 3.3 of the Contract, Professional agrees to assist CalOptima in the transfer of care of a Member. Professional shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Professional is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Professional agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Professional or Downstream Entity; (iii) the merger, reorganization, or consolidation of Professional or Downstream Entity, with another entity with respect to which Professional or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Professional or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Professional or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Professional agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Professional's or its Subcontractor's possession.

20. In addition to Section 9.2 of Article IV of Attachment B of the Contract, Professional acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

# ADDENDUM 4

**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

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

0348-0046

| 1. Type of Federal Action: | 2. Status of Federal Action: | 3. Report Type: |
|---|---|---|
| contract<br>grant<br>cooperative agreement<br>loan<br>loan guarantee<br>loan insurance | bid/offer/application<br>initial award<br>post-award | initial filing<br>material change<br>For Material Change Only:<br>Year _____ quarter_______<br>date of last report |

| | |
|---|---|
| 4. Name and Address of Reporting Entity:<br>Prime Subawardee<br>Tier , if known:<br><br>Congressional District, If known: | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:<br><br>Congressional District, If known: |
| 6. Federal Department/Agency: | Federal Program Name/Description:<br><br>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):<br><br>(attach Continuation Sheets(s) | b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):<br><br>SF-LLL-A, If necessary) |
| Amount of Payment (check all that apply):<br>$ actual planned<br>Form of Payment (check all that apply):<br>a. cash<br>b. in-kind, specify: Nature<br>Value | Type of Payment (check all that apply):<br>a. retainer<br>b. one-time fee<br>c. commission<br>d. contingent fee<br>e. deferred<br>f. other, specify: |

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

| | |
|---|---|
| 16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure. | Signature:<br>Print Name:<br>Title:<br>Telephone No.: Date: |

| | |
|---|---|
| **Federal Use Only** | Authorized for Local Reproduction<br>Standard Form-LLL |

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

10. Consider Extending Primary Care and Specialist Physician Fee-for-Service Professional Services Contracts, Except Those Associated with Providence St. Joseph Heritage Healthcare and its Affiliates

**Contacts**

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

**Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend Primary Care and Specialist Physician fee-for-service (FFS) Professional Services contracts, except those associated with the Providence St. Joseph Heritage Healthcare and its Affiliates through June 30, 2022, under the same terms and conditions

**Background/Discussion**

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care and Specialist services on a fee-for-service (FFS) basis to Medi-Cal (CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A)), OneCare, OneCare Connect (including CCN) and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board. Staff is requesting authority to extend the Medi-Cal, OneCare Connect and PACE FFS Primary Care and Specialist Professional Services contracts, except those associated with St. Joseph Heritage Healthcare and its Affiliates, through June 30, 2022.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

**Fiscal Impact**

Management will include medical expenses related to the contract extensions in the upcoming Fiscal Year 2021-22 Operating Budget. To the extent there is any additional fiscal impact prior to the end of the fiscal year, such impact will be addressed in separate Board actions.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

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**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**

1. Contract Template: Professional Services Contract for FFS Physicians and Specialist Providers

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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# PROFESSIONAL SERVICES CONTRACT

## GENERAL PROVISIONS

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and _______________________ ("Professional"), with respect to the following:

## RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract through the Practitioners listed on Attachment C to CalOptima Members, as identified in Attachment A.

H. CalOptima and Professional desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

## ARTICLE 1

## ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Professional's Practitioners who own, are employed by, or under contract with, Professional, and who will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of

such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: Cal MediConnect Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

## ARTICLE 2
## DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 "Assigned Members" means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima's electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider's participation in the program.

2.7 "Behavioral Health Services" means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 "Cal MediConnect" is a program to furnish health care services to Medicare/Medi-Cal Members who are enrolled in CalOptima's Cal MediConnect program. Cal MediConnect is also referred to as OneCare Connect.

2.9 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 "CalOptima Direct" or "COD" means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 "CalOptima Direct—Administrative" or "COD-Administrative," provides services to Members who reside outside of CalOptima's service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 "CalOptima Policies" means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 "CalOptima Program(s)" means the Medi-Cal, Cal MediConnect, and PACE Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 "Care Management Services" means (i) providing Physician Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member's care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 "CCS Provider(s)" or "CCS-Paneled Provider(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 "Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

2.38 "HealthCare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.39 "Health Risk Assessment" or "HRA" means the assessment tool which identifies a Member's primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 "Hospital Services" means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 "Hospitalist" means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 "Individualized Care Plan" or "ICP" means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

2.43 "Interdisciplinary Care Team" or "ICT" means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 "Licenses" means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 "Medi-Cal Specialty Mental Health Services" mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 "Medical Necessity" or "Medically Necessary" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to

manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which

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treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

## ARTICLE 3
## FUNCTIONS AND DUTIES OF PROFESSIONAL

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least thirty (30) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall provide CalOptima with the following information, as applicable: (a) names of all officers of Professional's governing board; (b) names of all owners of Professional; (c) names of stockholders owning more than five percent (5%) of the stock issued by Professional; and (d) names of major creditors holding more than five percent (5%) of the debt of Professional. Professional shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Professional shall notify CalOptima immediately of any changes to the information included by Professional in the disclosure forms submitted to CalOptima.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 CalOptima QMI Program. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Professional. Professional agrees that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Professional further agrees to participate in all quality improvement studies including, but not limited to HEDIS data collection. Professional shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Professional Services (*e.g.,* medical necessity) and shall accept as final all decisions regarding disputes over Physician Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

Professional shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional 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. Professional and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national

origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional'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.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, 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.

Professional and its Downstream Entities 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 Professional's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional's and its Subcontractors noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Professional may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional 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 Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any

advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Professional shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or

alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional 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. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a

significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima.

CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data."

## ARTICLE 4
## FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract.

## ARTICLE 5
## INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of

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such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

## ARTICLE 6
## RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For

purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

## ARTICLE 7
## TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2021. This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract."

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally- approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

c) Cal MediConnect program beneficiaries as described in this Section shall be paid at the Medicare rate for services covered under the Medicare benefit. Services for benefits not covered by Medicare but covered under Medi-Cal, the Medi-Cal rate as stated in the above paragraph "a" shall apply.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

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7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

7.10.1 Professional shall not furnish services under CalOptima's Cal MediConnect program unless and until CalOptima is authorized by DHCS and CMS to proceed with such program and CalOptima provides written notice to Professional of the commencement date of such services.

## ARTICLE 8
## GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

## ARTICLE 9
## MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings

against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

______________________________
Name

______________________________
Title

______________________________
Address

______________________________

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in

good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional 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.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

9.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.17 Debarment Certification. Professional agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) 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.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

9.17.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

## ARTICLE 10
## EXECUTION

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

| Professional | CalOptima |
|---|---|
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | Ladan Khamseh |
| Print Name | Print Name |
| ______________________ | Chief Operating Officer |
| Title | Title |
| ______________________ | ______________________ |
| Date | Date |

## ATTACHMENT A

## CONTRACTED SERVICES

### ARTICLE 1
### CALOPTIMA PROGRAMS AND SERVICES

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Cal-MediConnect Program (Members Dually Eligible for Medicare and Medi-Cal Benefit) Includes Community Network

__X__ Medi-Cal Program (Community Network and COD Administrative)

__X__ PACE Program

1.2 Physician Services. Professional shall furnish:

__X__ Primary Care Provider Covered Services to eligible Members in the CalOptima program, who are assigned to Professional.

__X__ Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

### ARTICLE 2
### GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services

must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member’s medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members’ care and coordinating utilization of services to facilitate the return of Member’s care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member’s care. Professional shall forward the results of diagnostic procedures and consultations to Member’s assigned PCP in a timely manner in order to ensure that the Member’s care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima’s Policies and for periodicity and content of pediatric

health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall

include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

## ATTACHMENT B

## COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

## I. MEDI-CAL PROGRAM

### A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

   1.2. of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

   1.3. NOT APPLICABLE TO THIS CONTRACT

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XXX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

   2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

### B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. **Specialist Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

   1.2. NOT APPLICABLE TO THIS CONTRACT

   1.3. **Non Professional** services shall be paid at **XX** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. NOT APPLICABLE TO THIS CONTRACT

1.5. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.6. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

| CPT Code Range | Type of Service | Fee Schedule |
|---|---|---|
| **10000-69999** | **Surgical Range** | |
| **70000-79999** | **Radiology and Radiation Therapy Professional and Technical Components** | |
| **80000-89999** | **Lab and Pathology** | |
| **90000-99999** | **Professional Services** | |
| **HCPC Codes** | | |

1.6.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

1.6.2. Subject to approval by the CalOptima Board of Directors, the specialist rates identified in Section 1.6 shall be extended effective **July 1, 2018**.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## II. PACE PROGRAM

For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or
2. **XX** of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.
3. Prior authorization rules apply for payment of services.
4. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
5. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   5.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid at **XX** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   5.2 Professional shall utilize current payment codes and modifiers for Medicare.

   5.3. CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   5.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

6. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

## III. CAL MEDICONNECT

For Covered Services provided to Cal MediConnect Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima the lesser of:

1. Billed charges, or XX of the Current Medicare Allowable Participating Provider Fee Schedule for locality 26.
2. Prior authorization rules apply for payment of services.
3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.
4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes will be paid at XX of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided.

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance to the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

## IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. NOT APPLICABLE TO THIS CONTRACT

8. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

9. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   9.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   9.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

1) accept the plan payment as payment in full, or

2) bill the appropriate State source.

9.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

9.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

9.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

**ATTACHMENT B-1**
**SUPPLEMENTAL COMPENSATION**
**PROPOSITION 56 FUNDING**

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services (both as defined in this Attachment B-1) effective July 1, 2017.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:

   1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

   1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

   1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. CalOptima shall administer the Prop 56 increase in accordance with the Exhibit for the applicable State fiscal year attached to this Attachment, applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.

3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments for dates of service between July 1, 2017 and July 30, 2019 and beyond if so directed by DHCS.

4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.

5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

6. Notwithstanding other provisions of this Attachment B-1, effective July 1, 2020, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

**ATTACHMENT B-1, Exhibit 1**
**SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |

**ATTACHMENT B-1, Exhibit 2**
**SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)**

CalOptima shall make payments to Eligible Contracted Providers based on Dates of Service referenced in this Attachment and based on the codes and amounts in the table below.

| CPT | Description | Directed Payment |
|---|---|---|
| 99201 | Office/Outpatient Visit New | |
| 99202 | Office/Outpatient Visit New | |
| 99203 | Office/Outpatient Visit New | |
| 99204 | Office/Outpatient Visit New | |
| 99205 | Office/Outpatient Visit New | |
| 99211 | Office/Outpatient Visit Est | |
| 99212 | Office/Outpatient Visit Est | |
| 99213 | Office/Outpatient Visit Est | |
| 99214 | Office/Outpatient Visit Est | |
| 99215 | Office/Outpatient Visit Est | |
| 90791 | Psychiatric Diagnostic Eval | |
| 90792 | Psychiatric Diagnostic Eval with medical Services | |
| 90863 | Pharmacologic Management. | |
| 99381 | Initial Comprehensive Preventive Med E&M (<1-year-old) | |
| 99382 | Initial Comprehensive Preventive Med E&M (1-4 Years old | |
| 99383 | Initial Comprehensive Preventive Med E&M (5-11 years old) | |
| 99384 | Initial Comprehensive Preventive Med E&M (12-17 Years old) | |
| 99385 | Initial Comprehensive Preventive Med E&M (18-39 Years old) | |
| 99391 | Periodic comprehensive preventive med E&M (<1-year-old) | |
| 99392 | Periodic comprehensive preventive med E&M (1-4 years old) | |
| 99393 | Periodic comprehensive preventive med E&M (5-11 years old) | |
| 99394 | Periodic comprehensive preventive med E&M (12-17 years old) | |
| 99395 | Periodic comprehensive preventive med E&M (18-19 years old) | |

## ATTACHMENT C

## PROFESSIONAL / PRACTITIONER

Professional's Name ______________________________

Address ______________________________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________________

Note: The email address will be used to send communication electronically when applicable. Please indicate the appropriate contact's email address.

Date ______________________

This Attachment may be amended from time to time, and shall incorporate Practitioners who (i.) own, are employed by, or under contract with, Professional, including locum tenens; and (ii.) will perform Covered Services under this Contract. Only Practitioners who CalOptima has determined meet applicable CalOptima requirements and credentialing criteria may be listed in this Attachment. This Attachment may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least 30 days prior to the effective date of such addition or deletion. CalOptima shall maintain the roster of Professional's Practitioners with the applicable effective date of addition and/or deletion. Please attach separate list with the information below, if necessary.

**ATTACHMENT D**
**SPECIAL PROVISIONS**

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# ATTACHMENT E

## DISCLOSURE FORM

______________________________________________
Name of Provider

The undersigned hereby certifies that the following information regarding

______________________________________________ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____________________________________________________________________________

_____________________________________________________________________________

Co-Owner(s):

_____________________________________________________________________________

_____________________________________________________________________________

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____________________________________________________________________________

_____________________________________________________________________________

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____________________________________________________________________________

_____________________________________________________________________________

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____________________________________________________________________________

_____________________________________________________________________________

Dated: ____________________________

Signature: _______________________________________

Name: _______________________________________
(Please type or print)

Title: _______________________________________
(Please type or print)

**ADDENDUM 1**
**MEDI-CAL PROGRAM REQUIREMENTS**

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Programs: These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail. For purpose of this Addendum 1, "State Contract" means the written agreement between CalOptima and DHCS pursuant to which CalOptima is obligated to arrange and pay for the provision of Medi-Cal Covered Services to Members in Orange County, California.

1. Professional and other Providers of Services. Upon request, Professional shall provide CalOptima with a list of approved Practitioners providing Covered Services, together with any information requested by CalOptima for credentialing and/or the administration of its QMI Program. Professional shall, as warranted, immediately restrict or suspend Practitioners from providing Physician Services to Members when: (i) the Practitioner ceases to meet Minimum Provider Standards and/or other licensing/certification requirements or other professional standards described in this Contract; or (ii) CalOptima reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the applicable Practitioner that does or could adversely affect the health or safety of Members. Professional shall immediately notify CalOptima of any of Professional's Practitioner(s) who ceases to meet Minimum Provider Standards or licensing/certification requirements and Professional's action.

2. Emergency Services. Professional shall comply with all applicable State and Federal laws and regulations, as well as State Contract, Exhibit A, Attachment 8, Provision 13, governing the provisions and payment of Emergency Services including, without limitation, the following requirements:

   2.1 Professional shall furnish Emergency Services on a twenty four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Professional for Emergency services without Prior Authorization.

   2.2 Payment will not be denied where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 2.28.

   2.3 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

   2.4 The attending emergency Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

   2.5 Professional shall refer any Community Network Member not assigned to Professional back to the assigned Primary Care Provider, and shall facilitate the transfer of any applicable records to such Physician.

   2.6 Professional and Professional's Practitioners shall be and remain during the period of this Contract duly licensed to practice in their profession in the State of California or in the state in which Professional will be providing Physician Services to Members. Professional is currently in good standing, and at all times during the term of this Contract shall maintain good standing, with the following:

      2.6.1 all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

      2.6.2 certification under Medi-Cal and Medicare; and

      2.6.3 Board certification to the extent required by CalOptima Policies.

3. Hospital Admissions. Professional may not admit a Member to a hospital on a non-emergency basis without first receiving Prior Authorization from CalOptima's UM Department. Professional shall coordinate care with Hospitalists for Member hospital admissions and provide history, medications, referrals and previous work-up information.

4. Admissions to Long Term Care Facility. Professional shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Professional shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long-term care, Professional shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

5. Confidentiality of Sensitive Services Information. If a Professional supplies Sensitive Services, including Family Planning Services, Professional shall comply with State confidentiality laws, regulations and other requirements relating to Members' Family Planning information and records and Professional acknowledges that he or she is solely responsible for developing and implementing Policies and Procedures to ensure compliance with such confidentiality requirements. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Professional shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

6. Linguistic and Cultural Sensitivity Services. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its Policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level. Professional shall comply with the language assistance standards developed pursuant to Health & Safety Code section 1367.01.

7. Provision of Interpreters. Professional shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract and CalOptima Policies. Professional shall ensure provision of interpreter services to Members at all provider sites.

   Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Professional shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

   The provision of interpreter services required by this section may be undertaken in accordance with the Provider Manual and CalOptima Policy.

8. Overpayments and CalOptima Right to Recover. Professional has an obligation to report any overpayment identified by Professional, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Professional, or of receipt of notice of an overpayment identified by CalOptima. Professional acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Professional, CalOptima shall have the right to recover such amounts from Professional by recoupment or offset from current or future amounts due from CalOptima to Professional, after giving Professional notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Professional to CalOptima, including, but not limited to, amounts due because of:

8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

8.3 Unpaid Conlon reimbursements owed by Professional to a Member.

8.4 Payments made for services provided by a Professional that has entered into a private contract with a Medicare beneficiary for Covered Services.

9. Professional Subcontracts. If the Professional is an individual sole practitioner, the Professional shall not subcontract for the provision of Covered Services to Members.

10. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. CalOptima will reimburse Professional at the current CalOptima Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

11. Electronic Transactions. Professional agrees to engage in exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions.

12. Records Retention. Professional and its Subcontractors shall maintain and retain all records of all items and services provided to Members: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Professional's or Subcontractor's place of business or at such mutually agreeable location in California; and (c) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Physician's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

13. Access to Books and Records.

13.1 Professional agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and the State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Professional's place of business or at such other mutually agreeable location in California, (c) in a form maintained in accordance with the general

standards applicable to such book or record keeping, (d) for a term of at least ten (10) years from the final date of the State Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, and (e) including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Professional shall provide access to all security areas and shall provide reasonable cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Professional at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

13.2 Through the end of the records retention period specified in Section 13.1, above, Professional shall allow CalOptima, DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' External Quality Review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Professional pertaining to these services at any time pursuant to 42 CFR 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 13.1, above, Professional shall furnish any record, or copy of it, to CalOptima, DHCS, or any other entity listed in this section, at Professional's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Professional's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations, as well as requirements of DHCS and this Contract.

13.3 Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of Professional's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Professional, Subcontractor, and provider facilities, management systems and procedures, and books and records, as the Director of DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State of California, and their authorized representatives and designees, will have the right to premises access, with or without notice to Professional. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima or authorized State agencies will have access to all security areas and Professional will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Professional or the Subcontractor(s).

13.4 The provisions of this Section 13 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

14. Form of Records. Professional's books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

15. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Professional site.

16. Downstream Contracts. In the event that Professional is allowed to Subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS. Professional shall ensure that all Subcontracts are in writing and require that the Professional and its Subcontractors:

    16.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

    16.2 Retain such books and all records and documents through the end of the records retention period specified in Section 13.1

17. Assignment and Delegation. Professional agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Professional or Subcontractor; (iii) the merger, reorganization, or consolidation of Professional or Subcontractor with another entity with respect to which Professional or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Professional or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Professional or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

19. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional related to this Contract.

19.1 Professional further agrees to timely gather, preserve, and provide to DHCS any records in the Professional's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

20. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

21. LEFT BLANK INTENTIONALLY

22. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

23. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Providers 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 Professional, its employees, agents, or Providers as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Providers shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Providers shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional:

23.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

23.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

23.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

23.4 will, at the termination of this Contract, return all such information to CalOptima that Professional is not legally or contractually required to retain and make available, and maintain all other such information according to written procedures sent to the Professional by CalOptima for this purpose.

24. DHCS Directions. If required by DHCS, Professional shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

25. Additional Subcontracting Requirements. Professional shall require all Subcontractors that relate to the provision of Medi-Cal Covered Services to Members pursuant to this Contract include the following:

25.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

25.2 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

25.3 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

25.4 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 1, and (b) to notify DHCS in the manner provided in Section 7.10 of the Contract in the event the Subcontract is amended or terminated

25.5 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Section 3.38 of the Contract and Section 26 of this Addendum 1, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 19 and 19.1 of this Addendum 1.

25.6 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 13 of this Addendum 1.

25.7 An agreement to maintain and make available to DHCS, CalOptima, and/or Professional, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Sections 16.1 to 16.2 of this Addendum 1.

25.8 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies) and the requirements set forth in Section 27 of this Addendum 1.

25.9 An agreement to assist Professional and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 29 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section IV.9 of Attachment B of the Contract.

25.11 An agreement to the requirements for cultural and linguistic sensitivity and the provision of interpreter services to be provided as set forth in Sections 6 and 7 of this Addendum 1.

25.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal Members, as provided in CalOptima Policies relative to the Medi-Cal program, and excluding any contract disputes between Professional and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

25.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 3.17 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima, and/or Professional determines that the Subcontractor has not performed satisfactorily.

25.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 32 of this Addendum 1 and Section 6.5.3 of the Contract.

25.15 An agreement by the Professional to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.6 of the Contract.

25.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 to 6.3 of the Contract and Sections 12 to 13 of this Addendum 1.

25.17 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

26. Professional shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

27. Professional shall comply with (a) DHCS Medi-Cal Provider Bulletins and Manuals, (b) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and (c) all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

28. Professional shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by Professional pursuant to the Contract.

29. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Professional shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, and the continuity, to the extent possible, of Member-Provider relationships. Cost of reproduction shall be borne by DHCS and CalOptima as applicable.

29.1 Professional agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

30. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

31. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

32. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with the Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use it as the Professional is able for the purpose of Member care coordination.

**ADDENDUM 2**
**PACE PROGRAM REQUIREMENTS**

The terms and requirements of this Addendum 2 shall apply for services provided by Professional to Members who are enrolled in the CalOptima PACE program only. These terms and conditions are additive to those contained in the General Provisions. In the event that these terms and conditions conflict with those in the General Provisions, these terms and conditions shall prevail.

1. State Approval and Termination.

1.1 This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

1.2 Amendments to this Contract and amendments to any subcontract agreements between Professional and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

1.3 CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Professional of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Professional's Responsibilities applicable to providing services to CalOptima PACE Members. Professional shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE Members, Professional agrees to do the following:

2.1 Professional shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

2.2 Duties Related to Professional's Position. Professional shall perform all the duties related to its position, as specified in this Contract.

2.3 Services Authorized. Professional shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

2.4 Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Professional shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5 Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Professional will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Professional pursuant to this Contract.

2.6 Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.7 Coverage of Non-Network Providers. Professional agrees that should arrangements be made by Professional with another physician/provider who is not under contract with CalOptima to provider Covered Services required under this Contract, such physician/provider shall (a) accept Professional's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Professional's office, unless Professional has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.8 Participant Bill of Rights. Professional shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Professional.

2.9 Provision of Direct Care Services to PACE Participants. Professional hereby represents and warrants that Professional and all employees of Professional providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Professional agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Professional or any employee of Professional providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.9.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2. 9.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Professional furnishes;

2. 9.3 Have verified current certifications or licenses for their respective positions;

2. 9.4 Have not been excluded from participation in Medicare, or Medi-Cal;

2. 9.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2. 9.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2. 9.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2. 9.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Professional and PACE.

3. Records Retention. Professional and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving

matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Professional's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Professional shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Professional and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Professional's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Professional shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Professional and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Professional may possess in order to verify Professional's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All Medical Records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Practitioner or Subcontractor site.

6. Downstream Contracts. In the event that Professional is allowed to subcontract for services under this Contract, and does so subcontract, then Professional shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Professional, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions); (ii) the change

of more than twenty-five percent (25%) of the directors or trustees of Professional; (iii) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity; and/or (iv) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Professional shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Professional shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time may be of the essence in responding to such request. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Professional or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Professional and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Professional, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Professional and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Professional's obligations under this Contract. Professional and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

    12.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For

the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Professional from unauthorized disclosure. Professional may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Professional is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional or its Subcontractors, Professional:

12.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

13. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

## ADDENDUM 3
## CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Professional shall provide services or perform other activity pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS,
2. Professional shall (i) safeguard Member privacy and confidentiality of Member health records, (ii) comply with all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Professional and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Professional shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Professional shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Professional shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Professional acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with hospital actions required to comply with EMTALA.
7. Professional shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Professional shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Professional shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Professional shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
8. Professional shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
9. Professional shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Professional. Professional may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such Professional is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Professional for the provision of covered services under the CalOptima Cal MediConnect Program solely because Professional has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Professional represents and warrants that: (i) neither Professional nor any of its contracted Physicians, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Professional has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Professional knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Professional or any of its contracted Physicians, employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Professional agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Professional fails to comply with the above, CalOptima reserves the right to require Professional to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Professional shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Professional, Professional shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including, but not limited to, the following:

11.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 3.21 of the Contract.

11.1.2 An agreement to (i) Member financial protections in accordance with Section 9 of Article IV of Attachment B of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Professional, and (ii) safeguard Member privacy and confidentiality of Member health records.

11.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 3.18 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2 In addition to Section 11.1 of this Addendum 3, Professional shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Professional.

11.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and

diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 9.2 of Article IV of Attachment B of the Contract and Section 20 of this Addendum 3.

11.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7 An agreement that the medical provider assist the Professional and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.10 of the Contract in the event the subcontract is amended or terminated.

11.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under CalOptima Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Professional and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

11.2.10 An agreement to (i) participate and cooperate in equality improvement system as set forth in Section 3.17 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites.

12. Right of Inspection, Evaluation, and Audit of Records. Professional and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any other pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Professional and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 3.18 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Professional and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review, approve, and audit Professional's credentialing process on an ongoing basis.

15. Provider Terminations. In the event a provider is terminated for cause by Professional, Professional shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Professional terminates a provider for deficiencies in the quality of care provided, Professional shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 3.3 of the Contract, Professional agrees to assist CalOptima in the transfer of care of a Member. Professional shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Professional is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Professional agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Professional or Downstream Entity; (iii) the merger, reorganization, or consolidation of Professional or Downstream Entity, with another entity with respect to which Professional or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Professional or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Professional or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Professional agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Professional's or its Subcontractor's possession.

20. In addition to Section 9.2 of Article IV of Attachment B of the Contract, Professional acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

## ADDENDUM 4

**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

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:
- contract
- grant
- cooperative agreement
- loan
- loan guarantee
- loan insurance

2. Status of Federal Action:
- bid/offer/application
- initial award
- post-award

3. Report Type:
- initial filing
- material change

For Material Change Only:
Year _____ quarter_______
date of last report

4. Name and Address of Reporting Entity:
Prime Subawardee
Tier , if known:

Congressional District, If known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:

6. Federal Department/Agency:

Federal Program Name/Description:

CDFA Number, if applicable:

8. Federal Action Number, if known:

9. Award Amount, if known:

10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(attach Continuation Sheets(s) SF-LLL-A, If necessary)

Amount of Payment (check all that apply):
$ actual planned

Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature

Value

Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.

Signature:

Print Name:

Title:

Telephone No.: Date:

**Federal Use Only**

Authorized for Local Reproduction
Standard Form-LLL

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Consent Calendar**

11. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Employee Handbook and Human Resources Policy; Consider Authorizing Unbudgeted Sick Leave Expenditures

**Contacts**

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

**Recommended Actions**

1. Adopt Resolution Approving Updated CalOptima Employee Handbook and CalOptima Policy GA.8032 Employee Dress Code; and
2. Authorize unbudgeted expenditures in an amount not to exceed $227,239 from unspent budgeted funds to support supplemental paid sick leave for COVID-19 related leaves through June 30, 2021, consistent with the requirements of applicable federal and state laws.

**Background/Discussion**

On November 1, 1994, the Board of Directors (Board) delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation to the Board or a committee appointed by the Board for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, 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.

The following table references the existing Human Resources Policy and the Employee Handbook that have been updated and are being presented for review and approval.

| | Policy No./Name | Summary of Changes | Reason for Change |
|---|---|---|---|
| | GA.8032<br>Employee Dress Code | • Added language to reflect HR's practice to provide reasonable accommodations as required under applicable laws.<br>• Minor language changes to add clarity<br>• Addition of a provision subjecting employees to corrective action for violations of the policy. | • This policy provides guidelines for employees to maintain appropriate attire at the workplace.<br>• Biennial review of the policy<br>• Revised content to clarify and reflect current practices. |

| | Policy No./Name | Summary of Changes | Reason for Change |
|---|---|---|---|
| | Employee Handbook | • Revised statements related to 14 policies to be consistent with the current content of each policy.<br>• Updated names and positions<br>• Added additional information related to Workers' Compensation to enhance the employee's understanding of the program.<br>• Added a statement on the process for an employee who wishes to respond to a written performance evaluation.<br>• Added a statement regarding telephone privacy and recording of phone calls.<br>• Updated language consistent with new CFRA regulations.<br>• Consulted CalOptima COVID-19 Site-Specific Protection Plan and added applicable health statements that would be relevant over time.<br>• Removed Confirmation of Receipt page from document as the Employee Handbook is given to employees electronically on CalOptima University website and the Confirmation of Receipt is now presented, signed, tracked and reported electronically rather than via hard copy.<br>• Made minor grammatical and language changes for clarity. | • The handbook is a summary of CalOptima's mission, history, employment practices, key employee policies, procedures, and benefits<br>• The Employee Handbook is made available to employees at time of hire and available on an ongoing basis on CalOptima's InfoNet<br>• Biennial review of the policy<br>• Revised content to clarify and reflect current practices and updated laws and regulations |

In response to the Coronavirus health pandemic, both federal and state laws have been enacted to provide employees with supplemental paid leave options during specified date ranges. The legislation,

summarized below, has been implemented by CalOptima as required under applicable laws, regulations, or guidance.

- Federal Families First Coronavirus Response Act (FFCRA). Effective April 1, 2020 – December 31, 2020, the FCRA provides an additional 12 weeks of partially paid leave under FMLA and 80 hours paid sick leave for purposes arising under the COVID-19 pandemic. FFCRA applies to public agencies regardless of size. An employer of a health care provider could elect to exclude such workers from these emergency paid sick leave requirements. The Department of Labor subsequently amended the definition of "health care provider" in the regulations to only include workers who provide direct patient care and clarified that workers in a healthcare setting who were not involved in providing health care (such as IT professionals, HR personnel, building maintenance, etc.) were not exempt from the FFCRA requirements. The FFCRA paid leave requirements provides up to 12 weeks paid sick leave, up to $200 per day, and applies only to leaves related to coronavirus, including, but not limited to, caring for a child in case of COVID-related school or place of care closure due to coronavirus. Employees subject to a qualifying quarantine order, experiencing COVID-19 symptoms, seeking medical diagnosis, or acting as a caregiver could receive up to 80 hours of COVID-19 related supplemental paid sick leave of up to $511 per day.

- 2020 California Supplemental Paid Sick Leave. Effective September 19, 2020 - December 31, 2020, California Supplemental Paid Sick Leave applies to employees who work for employers who have 500 or more employees nationwide and includes COVID-19 related supplemental paid sick leave of up to 80 hours total, with a maximum payment of $511 per day. This law extends COVID-19 Supplemental Paid Sick Leave to health care employees and emergency responders who were not extended paid sick leave by their employers under the FFCRA, and applies without regard to the number of employees employed by their employer.

- 2021 California COVID-19 Supplemental Paid Sick Leave. Senate Bill 95 (SB 95), effective retroactively to January 1, 2021 and remaining in effect through September 30, 2021, provides up to 80 hours of paid sick leave for those qualified individuals who are unable to work or telework due to a qualifying COVID-19 reason, including, but not limited to, caring of oneself during isolation, caring for a family member during isolation, seeking a vaccine and for vaccine-related symptoms. As with its federal and state law predecessors, this law provides for a daily maximum of $511 for qualifying reasons related to COVID-19.

These COVID-19 leave requirements are provided in addition to CalOptima's current PTO and protected leave benefits. CalOptima management has implemented these requirements by creating new payroll codes to track and report the respective mandated leave entitlements. Management has communicated the changes to employees in compliance with all applicable laws through email announcements, physical postings onsite, and electronic posting on CalOptima's internal InfoNet that is accessible by all employees. The use of regular and temporary telework has been a mitigating factor to reduce the use and costs of these paid leaves. Requests for future and retroactive leaves are reviewed by Human Resources for eligibility with the applicable laws. Employees taking time off to obtain vaccinations may report that time to HR, and their time off is credited towards their 2021 COVID-19

Supplemental Paid Sick Leave. Out of state teleworkers will receive the greater of the California or their home state leave entitlements for purposes of COVID-19 paid leave supplements. CalOptima management will continue to monitor changes in legislation that relates to paid sick leave to ensure full compliance with all applicable laws.

Management projects that the fiscal impact for mandated paid sick time for COVID-19 related leaves will not exceed $227,239 through June 30, 2021. This estimate is based on the following factors.

- Projected costs for the period of April 2, 2020 through June 30, 2020 are expected to total approximately $3,408;
- Projected costs for the July 1, 2020 through December 31, 2020 period are expected to total $111,831; and
- Projected costs for the January 1, 2021 through June 30, 2021 period are expected to total approximately $112,000.

**Fiscal Impact**

The recommended action to adopt a resolution to approve revisions to CalOptima's Employee Handbook and CalOptima Policy GA.8032 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

The fiscal impact for the mandated paid sick leave for COVID-19 related leaves through June 30, 2021, is also expected to be budget neutral. Any adjustments or accruals for prior periods will be recognized in the current fiscal year. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2020-21 Operating Budget on June 4, 2010, will fund this benefit change. The total cost for the benefit change through June 30, 2021, is not expected to exceed $227,239.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Resolution No. 21-0506-01, Approve Updated CalOptima Employee Handbook and Human Resources Policy
2. Revised CalOptima Policy GA.8032: Employee Dress Code (redlined and clean copies)
3. Updated CalOptima Employee Handbook (redlined and clean copies)
4. Families First Coronavirus Response Act (FFCRA)
5. 2020 California COVID-19 Supplemental Paid Sick Leave
6. 2021 California COVID-19 Supplemental Paid Sick Leave

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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# RESOLUTION NO. 21-0506-01

# RESOLUTION OF THE BOARD OF DIRECTORS

# ORANGE COUNTY HEALTH AUTHORITY
**d.b.a. CalOptima**

## APPROVE UPDATED CALOPTIMA EMPLOYEE HANDBOOK AND HUMAN RESOURCES POLICY

**WHEREAS,** section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide 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; and

**WHEREAS,** in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, 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 for that purpose.

**NOW, THEREFORE, BE IT RESOLVED**:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Employee Handbook and CalOptima Policy: GA.8032: Employee Dress Code

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 6th day of May 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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| | |
|---|---|
| Policy: | GA.8032 |
| Title: | **Employee Dress Code** |
| Department: | CalOptima Administrative |
| Section: | Human Resources |
| *CEO Approval*: | */s/* |
| Effective Date: | 01/05/2012 |
| Revised Date: | TBD |
| Applicable to: | ☐ Medi-Cal<br>☐ OneCare<br>☐ OneCare Connect<br>☐ PACE<br>☒ Administrative |

For 20210506 BOD Review Only

## I. PURPOSE

This policy sets forth the guidelines CalOptima employees shall follow to maintain appropriate attire at the workplace.

## II. POLICY

A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism.

B. There may be times that Management requires employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the company at an outside community function.

C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.

D. As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified:

   1. The week of Thanksgiving;

   2. The period between Christmas and New Year's Day;

   3. The period between Memorial Day and Labor Day; and

   4. National Customer Service Week (First week of October).

E. ~~Management within each department~~The Human Resources (HR) Department will consider reasonable accommodation requests in accordance with the Fair Employment and Housing Act, Americans with Disabilities Act, Workplace Religious Freedom Act, and any other applicable laws and statutes.

F. Department management shall have the discretion to determine and submit written job duty appropriate attire and grooming requirements for employees and independent contractors ~~based upon job duties~~to the HR Department for approval.

~~E.~~G. Employees may be subject to corrective action, up to and including termination, for violations of CalOptima Policy GA.8032: Employee Dress Code.

## III. PROCEDURE

| Responsible Party | Action |
|---|---|
| Employee | 1. Sign the Dress Code Acknowledgment Form upon hire.<br>2. Adhere to the requirements in this policy. |
| Manager | 1. Interpret and enforce dress and grooming standards in their area of responsibility.<br>2. If employee attire is inappropriate, the manager will address employee immediately. |
| Human Resources | 1. Provide employees the Dress Code Policy and Agreement in the new hire packet.<br>2. File the Agreement in the employee's personnel file. |

## IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

## V. REFERENCES

A. CalOptima Employee Handbook
~~B. CalOptima Policy GA.8000: Glossary of Terms~~

## VI. REGULATORY AGENCY APPROVALS

None to Date

## VII. BOARD ACTIONS

| Date | Meeting |
|---|---|
| 01/05/2012 | Regular Meeting of the CalOptima Board of Directors |
| 05/01/2014 | Regular Meeting of the CalOptima Board of Directors |
| 11/03/2016 | Regular Meeting of the CalOptima Board of Directors |
| 10/04/2018 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/05/2012 | GA.8032 | Employee Dress Code | Administrative |
| Revised | 02/01/2014 | GA.8032 | Employee Dress Code | Administrative |
| Revised | 11/03/2016 | GA.8032 | Employee Dress Code | Administrative |
| Revised | 10/04/2018 | GA.8032 | Employee Dress Code | Administrative |
| Revised | TBD | GA.8032 | Employee Dress Code | Administrative |

For 20210506 BOD Review Only

1 IX. GLOSSARY
2

| Term | Definition |
|---|---|
| Business Casual Attire | Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be compatible with a professional environment and clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards, and no more than three and one-half (3 1/2) inches in height. In all cases, management within each respective department will define "appropriate" Business Casual Attire.<br><br>Business Casual Attire does not include:<br><br>▪ Jeans (or any type of denim or any color jeans or overalls)<br>▪ Spaghetti strap shirts, casual tank tops, halter tops, or tube tops<br>▪ See-through clothing<br>▪ Short skirts (where the length and/or fit is incompatible with a professional environment)<br>▪ Any type of shorts<br>▪ Casual sandals (such as flip flops, slide sandals or beach attire)<br>▪ Tennis or canvas shoes<br>▪ Any footwear without a back or backstrap<br>▪ Capri pants (unless part of a professional dress suit or two-piece business outfit)<br>▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols<br>▪ Clothing that reveals undergarments or parts of the body incompatible with a professional setting<br>▪ Hats, unless prior approval from Human Resources is given |
| CalOptima Logo Attire | CalOptima Logo Attire includes sweaters, dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans or capri pants from Monday through Thursday. |

For 20210506 BOD Review Only

| Term | Definition |
|---|---|
| Casual Attire | Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be compatible with a professional environment and neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals with a backstrap, tennis shoes, or other casual clothing in good condition. Leggings are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire.<br><br>Casual Attire does not include:<br><br>▪ Any type of jogging or sweat suits/sweatpants<br>▪ Spaghetti strap tops, casual tank tops, halter tops, or tube tops<br>▪ Casual sandals (such as flip flops, slide sandals or beach attire)<br>▪ Any footwear without a back or backstrap<br>▪ House slippers<br>▪ Yoga or workout pants<br>▪ See-through clothing<br>▪ Ripped jeans (including shredded jeans)<br>▪ Any type of shorts<br>▪ Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment<br>▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos<br>▪ Hats, unless prior approval from Human Resources is given |

1

For 20210506 BOD Review Only

**CalOptima Dress Code Acknowledgment Form**

I acknowledge that I have reviewed CalOptima Policy GA.8032: Employee Dress Code, and I agree to adhere to the terms and conditions of employment as outlined in the policy.

Employee Signature: ______________________________

Date: ______________________________

For 20210506 BOD Review Only

Revised: TBD

| | |
|---|---|
| Policy: | GA.8032 |
| Title: | **Employee Dress Code** |
| Department: | CalOptima Administrative |
| Section: | Human Resources |
| *CEO Approval*: | */s/* |
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| Applicable to: | ☐ Medi-Cal<br>☐ OneCare<br>☐ OneCare Connect<br>☐ PACE<br>☒ Administrative |

For 20210506 BOD Review Only

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4 the workplace.
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8 A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday
9 through Thursday. Employees must choose Business Casual Attire that communicates
10 professionalism.
11
12 B. There may be times that Management requires employees to dress in customary Business
13 Professional Attire, including, but not limited to, when presenting to the Board of Directors,
14 meeting with members of the business community, or representing the company at an outside
15 community function.
16
17 C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.
18
19 D. As a benefit, employees may dress in Casual Attire every Friday and every year during the
20 following times, unless otherwise specified:
21
22 1. The week of Thanksgiving;
23
24 2. The period between Christmas and New Year's Day;
25
26 3. The period between Memorial Day and Labor Day; and
27
28 4. National Customer Service Week (First week of October).
29
30 E. The Human Resources (HR) Department will consider reasonable accommodation requests in
31 accordance with the Fair Employment and Housing Act, Americans with Disabilities Act,
32 Workplace Religious Freedom Act, and any other applicable laws and statutes.
33
34 F. Department management shall have the discretion to determine and submit written job duty
35 appropriate attire and grooming requirements for employees and independent contractors to the HR
36 Department for approval.
37

G. Employees may be subject to corrective action, up to and including termination, for violations of CalOptima Policy GA.8032: Employee Dress Code.

## III. PROCEDURE

| Responsible Party | Action |
|---|---|
| Employee | 1. Sign the Dress Code Acknowledgment Form upon hire.<br>2. Adhere to the requirements in this policy. |
| Manager | 1. Interpret and enforce dress and grooming standards in their area of responsibility.<br>2. If employee attire is inappropriate, the manager will address employee immediately. |
| Human Resources | 1. Provide employees the Dress Code Policy and Agreement in the new hire packet.<br>2. File the Agreement in the employee's personnel file. |

## IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

## V. REFERENCES

A. CalOptima Employee Handbook

## VI. REGULATORY AGENCY APPROVALS

None to Date

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| Revised | TBD | GA.8032 | Employee Dress Code | Administrative |

For 20210506 BOD Review Only


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1 **IX. GLOSSARY**
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For 20210506 BOD Review Only

| Term | Definition |
|---|---|
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1

For 20210506 BOD Review Only

**CalOptima Dress Code Acknowledgment Form**

I acknowledge that I have reviewed CalOptima Policy GA.8032: Employee Dress Code, and I agree to adhere to the terms and conditions of employment as outlined in the policy.

Employee Signature: ______________________________

Date: ______________________________

For 20210506 BOD Review Only

Revised: TBD

****************************** COVER PAGE TO BE REPLACED ******************************

# Employee Handbook

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**Revised ~~February 7, 2019~~ May 06, 2021**

For 20210506 BOD Review Only

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# Welcome Letter
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Thank you for choosing CalOptima as your employer. The dedication of our employees is critical to CalOptima's ability to fulfill its mission and deliver access to quality, compassionate care to all members. Although we have evolved into a multi-faceted organization, we are grateful that our employees remain fully committed to ensuring that all programs, initiatives, and services are centered on meeting the health care needs of our members.

We at CalOptima understand that excellence in service to our members could not happen without our most valued resource, our dedicated and caring employees. Our diverse and mission-driven staff works tirelessly to meet our members' health care needs. I am exceptionally proud of our employees and am fully committed to maintaining the employee-focused culture in which our employees thrive.

With the support of CalOptima's Board of Directors and the Member and Provider Advisory Committees, our strong network of physicians and hospitals, and the dedication and drive of our employees, CalOptima looks forward to fully engaging in new opportunities that will improve the delivery of health care services to our members and the Orange County community.

On behalf of the administrative staff and the Board of Directors, welcome to CalOptima.

Sincerely,

~~Michael Schrader~~Richard Sanchez,
~~Interim~~ Chief Executive Officer

~~Paul Yost~~Andrew Do,
Chairman, CalOptima Board of Directors

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# Welcome to CalOptima

Welcome to CalOptima, a public agency and health plan that serves Orange County members of Medi-Cal, OneCare (Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), and PACE (Program of All-Inclusive Care for the Elderly). We believe you will find CalOptima an exciting organization with an important mission that is fulfilled through the collective efforts of our employees. You are joining our staff of dedicated and talented professionals, and we are confident that your skills and experience will assist us in achieving our mission.

# Our Personal Challenge

CalOptima's success is a direct result of the important contributions our employees make every day. We challenge all employees to keep our members front and center in all that they do. Our commitment to our members goes beyond the Customer Service Department, and we recognize that we would be unable to implement our important mission without our providers. We also recognize we need to serve all of our customers which include members, health networks, pharmacies, ancillary providers, physicians and their staff, and CalOptima employees.

But more than just meeting our members' needs, we strive to anticipate what they need and recommend it before they ask. We strive to be good stewards of public funds and honor our accountability to the community by working together to keep administrative costs as low as possible while improving the quality of care for our members and the effectiveness of our providers.

To do this, we must continually evaluate and reinvent the way we do business. Identifying opportunities for improving efficiency and effectiveness is the responsibility of all CalOptima team members. With your help, we will continue to build a team-oriented environment where innovation and flexibility are the standards for achieving our mission.

# Mission Statement

CalOptima's mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

# About This Handbook

This handbook is provided for your use as a reference and as a summary of CalOptima's mission, history, employment practices, key employee policies, procedures, and benefits. Because CalOptima is a dynamic and changing organization, at times it may be necessary to change or improve the policies and practices presented in this handbook. As CalOptima deems appropriate in its sole and absolute discretion, CalOptima reserves the right to amend, supplement or rescind this handbook, or any portion(s) herein, other than CalOptima's employment-at-will provisions. This handbook is not a contract, either express or implied, of continued employment.

Employees are encouraged and expected to read and familiarize themselves with the contents of this handbook and should consult with their manager and/or Human Resources to obtain clarification or detailed information regarding any policy, procedure, or practice outlined in this handbook.

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CalOptima is constantly striving to improve its policies, procedures, and services. We encourage employees to bring suggestions for improvements to their managers. By working together, we hope to share with all of our employees a sincere pride in our workplace and the services we are all here to provide.

This handbook supersedes all previously issued handbooks but does not supersede applicable federal, state, or local laws. Your manager or the Human Resources Department will be happy to answer any questions you may have.

## Right to Revise

This employee handbook summarizes some of the employment policies and practices of CalOptima in effect at the time of publication. A full list of policies may be found on the CalOptima InfoNet. All previously issued handbooks and any inconsistent policy statements or memoranda in effect prior to the effective date of publication are hereby superseded to the extent it conflicts with this handbook.

CalOptima reserves the right~~s~~ to revise, modify, delete, or add to any and/or all policies, procedures, work rules, or benefits stated in this handbook or in any other document, except for the policy of at-will employment.

Any written changes to this handbook will be made available to all employees via CalOptima's InfoNet and/or via email communication so that employees will be aware of the new policies or procedures. No oral statements, or representations, can in any way alter the provisions of this handbook.

Nothing in this employee handbook or in any other personnel document, including benefit plan descriptions, creates or is intended to create, a promise or representation of continued employment, for any employee.

## The History of CalOptima

CalOptima was established as part of a community effort to improve access to health care services for Orange County's low-income residents. The Orange County Board of Supervisors created CalOptima in 1993 as a county organized health system (COHS), which is a public agency. CalOptima is one of six COHS authorized by federal and state law to administer Medi-Cal benefits in California. This health care model allows local decision-making and ensures the plan is community-driven. CalOptima's mission is to provide access to quality health care services delivered in a cost-effective and compassionate manner.

In October 1995, CalOptima launched our Medi-Cal program with 180,000 members. That program remains our flagship today, with 2018 membership approaching 800,000 members. In the years since Medi-Cal was established, CalOptima went on to launch other programs for important segments of Orange County's low-income population.

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In 1998, CalOptima launched the Healthy Families Program (HFP) to provide health care coverage for children up to the age of nineteen (19) who met eligibility requirements based on family income. In 2013, HFP members were transitioned into CalOptima Medi-Cal at the direction of state legislation.

In 2005, CalOptima launched OneCare, our Medicare Advantage Special Needs Plan (HMO SNP). OneCare was created through a contract with the Centers for Medicare & Medicaid Services (CMS) to offer enhanced care coordination and streamlined health care delivery by combining the Medicare and Medi-Cal benefits into a single plan.

In 2013, CalOptima launched a Program of All-Inclusive Care for the Elderly (PACE), which is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elderly participants to help them continue living independently in the community.

In 2015, CalOptima launched OneCare Connect, a new health plan designed to simplify and improve health care for seniors and people with disabilities who have Medicare and Medi-Cal coverage. The plan combines Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support.

~~In the past four years,~~ CalOptima has maintained an outstanding record of quality for our members. Since 2014, we have been leading California~~'s top-rated health plan~~ in Medi-Cal quality, according to the National Committee for Quality Assurance. It is an honor we strive to uphold as we aim to fulfill our mission, but we cannot accomplish this alone. As a community health plan, we rely on private health care networks, including nearly 1,600 primary care providers and more than ~~6,~~7000 specialists to deliver the services our members need. Further, CalOptima is proud to administer our programs in a cost-effective manner and is consistently recognized as having one of the lowest administrative cost ratios among all Medi-Cal managed care plans in California.~~.~~

## At-Will Employment Status

CalOptima employees are at-will employees with no guarantee of employment for any specified term. CalOptima recognizes that relationships are not always mutually satisfactory. To protect both parties' rights, the employment relationship at CalOptima is terminable at-will, at the option of the employee, or CalOptima. An employee, or CalOptima, may terminate employment at any time, with or without cause, and with or without notice. As a professional courtesy, employees are encouraged to provide no less than two weeks' notice of termination to ensure adequate time to transition job responsibilities.

CalOptima reserves the right to change the conditions of an employee's employment including, but not limited to, compensation, duties, assignments, responsibilities, and location at any time, with or without cause. There are no written, oral, or implied promises of permanent, or continuing employment. This ~~policy~~ status supersedes any such agreements to the extent that any may exist.

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# Equal Employment Opportunity

CalOptima is an equal employment opportunity employer and makes all employment decisions on the basis of merit. CalOptima wants to have qualified employees in every job position. CalOptima prohibits unlawful discrimination against any employee, or applicant for employment, or those applying for or engaged in a paid or unpaid internship or training program leading to employment with CalOptima based on ~~n~~ race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, ~~S~~sex, ~~S~~sex ~~S~~stereotype, gender, ~~G~~gender ~~I~~identity, ~~G~~gender ~~E~~expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws. ~~race, religion/religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, sex, sex stereotype, gender, gender identity, gender expression, transitioning status, age, sexual orientation, immigration status, military status as a disabled veteran, or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws.~~ CalOptima also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics or is associated with a person who has, or is perceived as having, any of those characteristics.

Equal employment opportunity will be extended to all persons in all aspects of the employer-employee relationship, including recruitment or recruitment advertising, hiring, training, promotion, rates of pay or other forms of compensation, benefits, transfer, discipline, layoff or termination, career development opportunities, and social and recreational programs.

CalOptima prohibits retaliation for bringing a complaint of discrimination or harassment against any person employed, seeking employment, providing contract services, or applying for or engaged in a paid or unpaid internship, volunteer capacity, or training program leading to employment with CalOptima. CalOptima also prohibits retaliation to a person that assists someone with a complaint of discrimination or harassment. Retaliation may include threats, intimidation, and/or adverse actions related to employment~~.~~. Employees engaging in any actions which are retaliatory against another employee as described herein will be subjected to corrective action, up to and including termination of employment.

It is the responsibility of every manager and employee to conscientiously adhere to this policy.

See ~~Human Resources Policy~~CalOptima Policy GA.8025: Equal Employment Opportunity

# Unlawful Harassment and Discrimination

CalOptima is committed to providing a work environment that is free of unlawful harassment, discrimination, and retaliation. CalOptima prohibits unlawful harassment and/or discrimination against any employee, or applicant for employment, based on race, sex, sex stereotype, gender, gender identity, gender expression, transitioning status, age, color, national origin, immigration status, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status, medical condition, genetic information or any other protected characteristic is a violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as corrective action, up to and including termination of employment.

Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that is based on a protected characteristic and which creates an intimidating, offensive, or hostile work environment (must be severe or pervasive) or that interferes with work performance.

CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An

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employee who believes he or she is being, or has been, harassed or discriminated against based on a protected characteristic in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager or, if he or she prefers, to the Human Resources Department. Supervisors and managers must report incidents or claims of harassment immediately to the Human Resources Department. A Human Resources representative will investigate any and all complaints of unlawful harassment or discrimination and take appropriate preventive and/or corrective action when it is warranted. Reported complaints of unlawful harassment based on protected characteristic will be investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible, involving only the parties who have a need to know.

CalOptima is committed to educating all staff and leaders on harassment prevention upon hire and every two (2) years thereafter as required by law.

CalOptima will not tolerate retaliation against an employee for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints or for making any other complaint to the Human Resources Department. Employees engaging in any actions which are retaliatory against another employee will be subjected to corrective action, up to and including termination of employment.

It is the responsibility of every manager and employee to conscientiously adhere to this policy.

See ~~Human Resources Policy~~CalOptima Policy GA.8027: Unlawful Harassment.

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18 # Recruitment and Hiring
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# Job Posting

CalOptima supports the development and advancement of employees from within the organization, and that belief is supported by CalOptima's job posting process. Employees are responsible for taking ownership of their own career and checking new and current job postings for growth and advancement opportunities. CalOptima encourages employees to apply for promotions, or transfers, to open positions for which they meet the qualifications and minimum requirements.

Upon completion of the Request ~~To~~to Fill (RTF) process, positions will normally be posted internally and/or externally. Open positions must be posted internally for five (5) full business days before an offer can be made. On rare occasions, there may be situations where a position is not posted or is not posted for the full five (5) business days due to a sensitive business need. The exceptions from posting must be approved by the Chief Executive Officer.

Employees are not eligible to apply for posted jobs until they have completed at least six (6) months' service in their current position. Exceptions to the six (6) month waiting period may be made with approval from the ~~Executive Director of Human Resources~~Chief Executive Officer when in the best interest of CalOptima. Employees must possess the necessary education, skills, and experience for the job position, complete an internal job application (including an updated résumé) and be in good standing to apply for open positions. As a courtesy, it is recommended that employees notify their managers upon applying.

See ~~Human Resources Policy~~CalOptima Policy GA.8019: Promotions and Transfers

# Background Check

CalOptima believes that hiring qualified individuals to fill positions contributes to our overall strategic success. Background checks serve as an important part of the selection process. CalOptima employees have access to confidential, private, and protected health information. Through comprehensive background checks, CalOptima can obtain additional applicant-related information that helps determine the applicant's overall employability and ensures the protection of the people, property, and information of the organization.

CalOptima uses a third-party agency to conduct the background checks. The type of information that can be collected by this agency includes, but is not limited to, information pertaining to an individual's past employment, criminal background, education, character, credit record (where applicable), Department of Motor Vehicles (DMV) record, and reputation. Background checks are held confidentially in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

CalOptima conducts background checks on job applicants prior to commencement of employment. For promotions or transfer of employees to certain positions, or for unique circumstances, a post-employment background check may also be required. Falsification of information on the employment application or providing false information or incomplete information for the purpose of hiring or maintaining employment may result in corrective action, up to and including termination of employment. Employees shall timely notify HR of any licenses or certifications that they hold in California or other states that have been revoked, suspended, or restricted due to misconduct or disciplinary action. Employees shall also timely notify HR of any post-employment criminal convictions.

CalOptima also conducts exclusion monitoring through the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM) Website, and the Medi-Cal Suspended and Ineligible (S&I) Website. Any applicant found on the LEIE, SAM Website and/or Medi-Cal S&I Website and verified according to the Human Resources procedures cannot be hired with CalOptima. Similarly, any existing CalOptima employee found on the LEIE, SAM Website, and/or Medi-Cal S&I Website and verified according to the Human Resources procedures cannot be hired by or continue employment with CalOptima. Employees shall notify the Human Resources Department upon hire, or

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immediately any time thereafter, if the employee knows or has reason to know that the employee is excluded from a federally funded health care program and/or may be listed on the LEIE, SAM and/or Medi-Cal S&I Websites.

See ~~Human Resources Policy~~CalOptima Policy GA.8030: Background Check

## Proof of Right to Work

In accordance with federal law, all new hires will need to produce original documentation establishing their identity and authorization to be legally employed in the United States. In addition, each new hire is required to complete an INS Form I-9 swearing that they are legally employable in the United States. This verification must be completed as soon as possible after an offer of employment is made and in no event more than three (3) business days after an individual is hired. All offers of employment and continued employment for positions in the United States are conditioned on furnishing satisfactory evidence of identity and legal authority to work in the United States. Employees are responsible for timely providing updated evidence of continued legal authority to work post-employment prior to or upon the expiration of any previously submitted documentation. Employees who fail to timely furnish satisfactory evidence of continued legal authority to work post-employment prior to or upon the expiration date of previously submitted documentation may be terminated.

## Job Duties

In order to run a cost-effective program at CalOptima, it is important that employees are flexible and do what needs to be done to best serve the needs of our members and customers. During the employee's initial orientation and during the initial performance review, management will explain job responsibilities and the performance standards expected of their employees. A general description of the essential job functions is contained in each position's job description. Be aware that job responsibilities may evolve and/or change at any time during the employment relationship. From time to time, employees may be asked to work on special projects, and/or to assist with other work necessary or important to the operation of their department or CalOptima. Cooperation and assistance in performing such additional work is expected. Employees may be exposed to disagreeable conditions typical of working with individuals in distress, as well as encounter normal stress and pressure associated with a fast-paced environment, including various deadlines and interactions with regulators and/or member of the public. Work volume may be consistent or vary at different times of the year.

CalOptima reserves the right, at any time, with or without notice, to alter or change job responsibilities, reassign or transfer job positions, or assign additional job responsibilities.

## Employment Classifications

CalOptima uses the following specific classifications to describe the responsibilities and benefits of employment:

**Full-Time:** Employees who are regularly scheduled to work sixty (60) to eighty (80) hours a pay period and are eligible for all employer-provided health care and retirement benefits.

**Part-Time:** Employees who are regularly scheduled to work less than thirty (30) hours per week. Regular part-time employees are eligible for benefits and must pay an additional premium for health care benefits. PTO and flex holiday hours accrue on a prorated basis according to an employee's scheduled work hours (Full-Time Equivalent (FTE) Status).

**As-Needed:** Employees called to work on an as-needed basis. As-needed employees are employed for an indefinite duration and must work less than one-thousand (1,000) hours per fiscal year. These employees may not have regularly scheduled hours and do not earn any benefits, unless otherwise required by law, but may become

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eligible for paid sick leave. In certain circumstances, CalOptima may provide additional benefits to "As-Needed" employees averaging thirty (30) or more hours per week and working beyond the ninetieth (90) calendar day of employment. If this occurs, the employee may be converted to either full-time or part-time, depending on the circumstances, for the duration of the "As Needed" period, not to exceed one-thousand (1,000) hours per fiscal year, with an offer of associated benefits to comply with applicable laws, including, but not limited to, the Affordable Care Act (ACA).

**Temporary Agency Workers:** Workers who have been hired by and are paid by a temporary agency for an assignment generally not expected to last more than one-thousand (1,000) hours per fiscal year. Temporary agency workers are not eligible for CalOptima benefits, with the exception of CalPERS retirement benefits, where applicable.

**Salaried (Exempt)**: Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.

**Hourly (Non-Exempt):** Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on ~~a~~an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.

**Interns:** Paid interns are considered as-needed employees and must be enrolled in a college, or university, two (2) or four (4)-year degree program, an accredited vocational institution, or a graduate program, and may receive school credit for the internship. Unpaid interns shall not be deemed employees of CalOptima and must be enrolled in a college, or university, two (2) or four (4)-year degree program, an accredited vocational institution, or a graduate program, and ~~will~~must receive school credit for the internship.

CalOptima may change the employment classification/category of any employee at any time based on the nature of the employment assignment, operational efficiency, and to ensure compliance with applicable state and federal laws.

## Licenses and Certifications

When a required licensure and/or certification is/are mandated as part of a job position, or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). An employee is responsible for maintaining an active and current license and/or certification for the duration of his or her employment at CalOptima and providing proof of renewal to HR.

Employees shall notify HR immediately any time the employee knows, or has reason to know, of any prior action or action to be taken on the employee's required licensure and/or certification, or an event that occurs that could lead to such actions, including, but not limited to, pending, active, or resolved licensing board investigations, restrictions, allegations, revocations, suspensions, probation disciplinary actions, accidents, DUIs, etc. Failure to provide timely notification of such action(s) will be grounds for discipline, up to and including, termination.

See ~~Human Resources Policy~~CalOptima Policy GA.8033: License and Certification Tracking

## Employment of Relatives

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Management will exercise appropriate discretion in each case in the hiring and employment of relatives of current employees. “Relatives” are defined as any persons related by birth, marriage, domestic partner status, or legal guardianship including, but not limited to, the following relationships: spouse, child, step-child, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law and sister-in-law, or non-relatives of the same residence (housemate). If an employee knows or has reason to know that CalOptima is considering a relative of the employee for employment, that employee should make that fact known to the Human Resources Department.

Relatives of present employees may be hired by CalOptima only if:

- The applicant will not work directly for or directly supervising an existing employee; and
- A determination can be made that a potential for adverse impact on supervision, security, safety, or employee morale does not exist.

If the relationship is established after the employees’ employment with CalOptima has commenced (*e.g.,* two (2) existing employees marry, become related by marriage, or become housemates), and a determination has been made that the potential for adverse impact does exist, the department head in conjunction with the Human Resources Director, shall make reasonable efforts to minimize problems of supervision, safety, security, or morale, through reassignment of duties, relocation, or transfer to another position for which one (1) of the employees is qualified, if such position is available. If no reassignment or transfer is practical, CalOptima will terminate one (1) of the employees from employment. The decision as to which employee will be reassigned, transferred, or terminated will be at the discretion of CalOptima with consideration of CalOptima’s business needs. In certain situations, and at CalOptima’s sole discretion, CalOptima may provide the employees with an opportunity to decide which employee shall be reassigned, transferred, or terminated from employment. If the employees do not make a decision within thirty (30) business days, CalOptima shall automatically reassign or transfer one (1) of the employees, if practical, or terminate one (1) of the employees from employment.

See ~~Human Resources Policy~~CalOptima Policy GA.8051: Hiring of Relatives

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18 # Employee Performance and Responsibilities
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# Introduction to Employee Performance and Responsibilities

CalOptima strives to create an environment and culture where our employees can bring their knowledge, skills and talents to the forefront. We will treat our employees with respect and provide opportunities to be successful. CalOptima expects that each employee will strive to do his or her best as a CalOptima employee and that each employee will hold him or herself accountable for excellent performance, service, and results.

# Performance Evaluations

Evaluation of employees is a continuing process that takes place both formally and informally. Formal evaluations of performance and competence of regular employees shall take place following approximately ninety (90) calendar days of employment, based on the ~~dat~~date of hire, transfer, or promotion, and a minimum of one (1) time per year thereafter as part of the annual review process.

During the formal performance review process, ~~an~~ employees will have an~~the~~ opportunity to review their written performance evaluation and discuss it with their manager. If an ~~thean~~ employee questions a rating or comments included in the evaluation, ~~they~~they ~~arehe/she is~~ are encouraged to discuss it with thei~~theirhis/her~~ supervisor or manager at the time of ~~their~~the evaluation meeting. If the employee continues to have a concern, ~~theyhe/she~~ they may document it in the performance review system. Human Resources will be notified and will be available to help facilitate further conversation as needed.

# Initial Performance Review

CalOptima strives to hire qualified employees for the job. In order to ensure both the employee and CalOptima are meeting their respective expectations, an initial performance review is conducted following approximately ninety (90) calendar days of employment, based on the date of hire, transfer, or promotion, assuming the employee's employment has not otherwise been terminated. The manager will evaluate the employee's capabilities, work habits, compatibility with the job, interest in the job, and will discuss individual, department, and organizational expectations and performance. As an at-will employee, either party may terminate the employee's employment at any time, with or without cause, and with or without notice.

~~During the formal performance review process an employee will have an opportunity to review their written performance evaluation and discuss it with their manager. If the employee questions a rating or comments included in the evaluation, they are encouraged to discuss it with their manager at the time of their meeting. If the employee continues to have a concern, they may document it in the performance review system. Human Resources will be notified and will be available to help facilitate further conversation as needed.~~

# Job Performance, Conduct, and Corrective Action

CalOptima employees are bound to one another and our organization by its core values of Collaboration, Accountability, Respect, Excellence, and Stewardship. CalOptima expects its employees to be committed to ethical conduct, excellent service, consistent attendance, positive teamwork, and compliance with CalOptima policies and procedures. Our reputation is fundamental to our continued success. Each of us has a personal responsibility to ensure that our conduct is true to that objective.

Employees are expected to abide by CalOptima's Code of Conduct and conduct themselves in an intelligent, mature, and responsible manner and in accordance with applicable laws, regulations, policies, and generally accepted work behaviors. Appropriate conduct is expected at all times while employees are on duty and/or on CalOptima property. Any violation of CalOptima policies, or any act or incident of improper behavior or conduct, may warrant corrective action, up to and including termination. In this regard, CalOptima has outlined some

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examples of undesirable behavior and/or performance issues that may result in corrective action, up to and including termination, which include, but are not limited to:

- Unsatisfactory work quality, or quantity;
- Failure to meet performance standards;
- Behavioral-based problems that impact productivity, quality, service, or teamwork;
- Excessive absenteeism, tardiness, or abuse of break and lunch privileges;
- Creating conflict with co-workers, supervisors, members, or visitors;
- Damaging or unauthorized use of CalOptima-owned equipment;
- Failure to follow instructions, policies, regulations, laws, or CalOptima policies and procedures; and/or
- Failure to follow established safety regulations.

CalOptima strives to assist employees in understanding their performance expectations and in improving and preventing recurrence of undesirable behavior and/or performance issues. Employees are responsible for taking ownership in correcting their performance/behavior and in meeting their performance expectations.

CalOptima may, at its sole and complete discretion, initiate corrective action, where appropriate, in an effort to correct undesirable behavior and/or performance issues. The type of corrective action will depend on the nature of the offense, taking into consideration an employee's past performance and employment record, where applicable. Corrective action does not apply to all circumstances and will be employed on a case by case basis; however, CalOptima strives to assess corrective action in a fair and consistent manner.

As an at-will employee, CalOptima employees may be terminated at any time, with or without cause, and with or without advance notice. Employees are not guaranteed a right to a corrective action process prior to termination. CalOptima may skip one (1) or more steps, repeat certain steps, or skip the entire corrective action process altogether at CalOptima's sole and complete discretion. Serious performance, or behavioral, problems may result in immediate termination without corrective action prior to termination.

The corrective action process, when applied, is intended to give employees advance notice of problems with their conduct, or performance, in order to provide the employee with an opportunity to correct these problems. When used, the corrective action process may, in some but not all cases, include:

- Coaching discussion;
- Documented Counseling Memo;
- Written Warning;
- Performance Improvement Plan;
- Final Warning; and/or
- Termination.

Although one (1) or more of these steps may be taken in connection with a particular employee, no formal order or system is necessary.

Management may also place an employee on administrative leave with or without pay while HR conducts their investigation and/or final determination is pending and/or when there is a risk to CalOptima if the employee is permitted to continue in his or her role. The Human Resources Department shall work with management to address performance or behavioral issues and management actions.

See CalOptima Policy ~~Human Resources Policy~~ GA.8022: Performance and Behavior Standards

## Education and Training

CalOptima values the talent of its employees and encourages employees to continually develop their knowledge and skills to enhance their job responsibilities and prepare for future opportunities within the organization.

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CalOptima ~~provides~~delivers mandatory courses~~trainings~~, as designated by CalOptima leadership, Human Resources, the Office of Compliance, and departmental staff, as well as other optional training and personal development opportunities.

All mandatory courses and/or training sessions ~~trainings~~ must be completed within the~~a~~ specified time frame and may require documentation that the employee passed the associated exam in order to be deemed completed. Mandatory trainings include, but are not limited to, compliance and regulatory requirements and information, which may be administered in person, online, and/or through other means of communication. Employees failing to complete the mandatory training and/or pass the associated exam within the stated time frame may receive corrective action, up to and including termination of employment.

## Open Door

CalOptima has an open-door approach that encourages employee participation in decisions affecting them and their daily responsibilities at CalOptima and/or the organizational operations. Employees who have work-related concerns or complaints, or have suggestions to improve operations, are encouraged to discuss these matters in an informal and professional manner with their immediate supervisor and/or any other management representative with responsibility for their department. If such concern or complaint arises from any particular incident, employees should report these issues to their immediate supervisor or another management representative with responsibility for their department as soon as possible after the event or incident that caused the concern.

If the employee feels he or she cannot resolve his or her concern or complaint with management within his or her department, then the employee should contact Human Resources. CalOptima believes that employee concerns are best addressed through open communication and that the majority of misunderstandings can be resolved through open dialogue. Employees are encouraged to pursue discussion of their work-related concerns until the matter is fully resolved.

Although CalOptima cannot guarantee that employees will be satisfied with the result, CalOptima will attempt in each instance to explain the result or resolution to the employee if the employee is not satisfied. CalOptima will also attempt to keep all such expressions of concern, the results of interviews or an investigation and the terms of the resolution confidential. However, in the course of looking into and resolving the matter, some dissemination of information to others may be appropriate and/or necessary. No employee will receive corrective action, or otherwise penalized, for raising a good-faith work-related concern in keeping with the open-door approach.

Employees who conclude their work-related concerns should be brought to the attention of CalOptima by written complaint and formal review may refer to the Internal Complaint Review process set forth in this handbook.

## Internal Complaint Review

CalOptima strives to maintain a safe, positive, and pleasant environment for our employees. Employees who encounter work-related problems are encouraged to follow the steps outlined below to resolve their issues.

*Step One: Immediate Supervisor*
Should an employee have a problem or complaint, he or she should try to resolve this issue with his or her immediate supervisor. In most instances, a friendly talk with a supervisor can quickly resolve a problem. The supervisor will evaluate the matter and work to provide a timely solution.

*Step Two: Department Head*
If the problem is not resolved in Step One, an employee can refer the problem in writing to his or her department head. The department head should schedule a meeting to discuss the issue with the employee and, in turn, provide a timely solution, where applicable.

*Step Three: Human Resources Department*

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If, for any reason, an employee is dissatisfied with the decision of the department head, the employee can file a written complaint with the Human Resources Department. A representative from the Human Resources Department will review the complaint. When indicated, HR will meet separately with the employee and with others who are either named in the complaint, or who may have knowledge of the facts set forth in the complaint. CalOptima will attempt to treat all internal complaints and their follow-up review as confidential, recognizing, however, that in the course of reviewing, evaluating, and resolving internal complaints, some dissemination of information to others may be necessary. On completion of the review, the Human Resources Department will discuss any actions, or resolutions with the employee.

*Step Four: Appeal*
If the complaint is not resolved to the employee's satisfaction, the employee may submit a written request for review of the complaint to CalOptima's Executive Director of Human Resources. On completion of the appeal review, the employee will receive an oral or written summary of the review. Decisions resulting from appeal reviews by CalOptima's Executive Director of Human Resources will be final.

No employee will be retaliated or discriminated against in any way because he or she made a complaint in compliance with this process. Nothing in this Internal Complaint Review is intended to alter the at-will nature of employment.

## Attendance, Tardiness, and Reporting Absences

CalOptima counts on each employee's attendance and punctuality to provide efficient and consistent service to our members. We expect employees to report to work on time, observe the time limits for break and meal periods, and not leave work earlier without prior approval from their immediate supervisor. Regular and consistent attendance is an essential function of all job positions at CalOptima.

An employee's schedule is determined by the employee's immediate supervisor or the department supervisor based on CalOptima's core business hours to ensure coverage, where applicable.

Departments may establish guidelines for scheduling and reporting absences or time away from work that meets their specific business needs. If department specific guidelines have been established, employees are to follow the procedures of their respective department to the extent such procedures do not conflict with applicable laws. In the absence of a department-specific guideline or directive on attendance, a department shall adhere to the guidelines included in CalOptima Policy GA.8059: Attendance and Timekeeping.

If an employee is going to be absent or tardy, he or she must provide timely notice to his or her supervisor *before* his or her scheduled shift time. If the supervisor cannot be reached, the employee is expected to leave a message on the supervisor's voicemail or~~and~~ notify the department head or other designated department contact. Employees must provide the reason for the absence and the expected date of return. Employees must call in each day they will be absent or tardy, unless they are on a lengthier, pre-approved medical leave. Frequent tardiness or absenteeism will result in corrective action, up to and including termination. If an employee is absent for four (4) consecutive days, or more, of personal and unprotected sick time, a doctor's note is required on the first day back.

*Authorized Absence*
An authorized absence occurs when all four (4) of the following conditions are met:

1. The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to his or her ~~his/her~~ immediate supervisor or designee prior the commencement of his or her ~~his/her~~ shift;
2. The employee provides an acceptable reason to his or her immediate supervisor or designee;
3. Such absence request is approved by his or her immediate supervisor or designee;
4. The employee has sufficient accrued PTO to cover such absence or the supervisor waives this requirement because the employee has not yet accrued sufficient PTO.

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The employee's immediate supervisor may waive the notice requirement when it is warranted by the particular circumstances involved; for example, when an employee is unexpectedly taken ill and cannot call in a timely manner. Failure to meet these requirements may result in corrective action, up to and including termination, depending on the surrounding circumstances.

Absences of more than five (5) consecutive scheduled work days for an illness or pre-planned surgery must be submitted to and approved by HR.

*Unauthorized Absence*
An employee is considered to be on an unauthorized absence when one (1), or more, of the four (4) conditions mentioned above are not met. If an employee fails to provide a doctor's note after four (4) consecutive days, or more, on personal and unprotected sick time, then the days are considered unauthorized absences.

Unauthorized absences may result in corrective action, up to and including termination, depending on the surrounding circumstances. In addition, an employee is considered to have resigned when the employee fails to report to work without giving notice to and/or receiving authorization from his or her immediate supervisor for three (3) consecutive scheduled work days, unless the situation makes this impossible.

*Frequent or Prolonged Absenteeism or Tardiness*
Frequent or prolonged absenteeism or repeated tardiness, even when authorized, may result in corrective action, up to and including termination. Absences from work that qualify and are approved under CalOptima's leave of absence policy will not count toward excessive absenteeism.

See ~~Human Resources Policy~~ CalOptima Policy GA.8059 Attendance and Timekeeping

## Drug-Free and Alcohol-Free Workplace

CalOptima strives to maintain a workplace that is free of drugs and alcohol and discourages drug and alcohol abuse by its employees. CalOptima has a vital interest in maintaining a safe and productive work environment for its employees, members, and those who come into contact with CalOptima. Substance abuse is incompatible with the mission and interest of CalOptima. In accordance with federal law, marijuana and other cannabis products fall under the category of "illegal drugs". Employees who are under the influence of drugs and/or alcohol in the workplace can compromise CalOptima's interests, endanger their own health and safety and the health and safety of others, and can cause a loss of efficiency, productivity, or a disruptive working environment.

The following rules and standards of conduct apply to all employees either on CalOptima's property, working offsite, or on CalOptima business. Behavior that violates CalOptima policy includes:

- The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance;
- Possession, or use, of an illegal, or controlled, substance, or being under the influence of an illegal, or controlled, substance while on duty~~the job~~, or on/-in CalOptima property, except where the controlled substance is lawfully prescribed and used consistent with a doctor's authorization;
- Abuse of a legal drug or the purchase, sale, manufacture, distribution, dispensation, or any legal prescription drug in a manner inconsistent with law;
- Operating a CalOptima owned or leased vehicle or conducting CalOptima business in a personal vehicle ~~Driving a CalOptima owned, or leased, vehicle~~ while under the influence of alcohol, illegal drugs, or controlled substance(s); and/or
- Distribution, sale, or purchase of alcohol and/or an illegal, or controlled, substance while on on-duty or on or in CalOptima Property.

Violation of these rules ~~and standards of conduct~~ will not be tolerated, and CalOptima shall take appropriate actions including, but not limited to, employee corrective action, up to and including termination. CalOptima also

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may bring the matter to the attention of appropriate law enforcement authorities and/or professional licensing authorities~~y~~.

CalOptima reserves the right to conduct searches of CalOptima property or employees and/or their personal property, and to implement other measures necessary to deter and detect abuse of this policy. CalOptima asserts its legal right and prerogative to test certain employees for substance abuse. These employees may be asked to submit a medical examination and/or to submit to urine testing for illegal drugs, controlled substances, or alcohol under the following circumstances:

- Employees in certain positions are required to pass a pre-employment urine drug test.
- Employees in certain positions may be subject to random drug testing.
- If the CalOptima employee is involved in a traffic accident and there is reasonable suspicion of the involvement of drugs and/or alcohol.
- If an employee's supervisor, manager, Human Resources representative or other leader -suspects an employee is under the influence of drugs and/or alcohol and observes ~~one (1)~~two (2) or more symptoms.

Employee acceptance of medical examinations and testing, when requested by CalOptima for one (1) of the reasons set forth above, is a mandatory condition of employment. Refusal to submit to such medical examinations and tests constitutes a violation of CalOptima's policy and is grounds for corrective action, up to and including immediate termination of employment.

Any employee who is using prescription, or over-the-counter drugs, that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting, or resuming, work. Any prescription medication, which must be taken while at work, should be kept in the original prescription container and used in accordance with the prescribing physician's instructions. CalOptima reserves the right to require written medical certification of the employee's ability to perform his or her duties while taking any prescribed medication.

All CalOptima employees who provide health care services and personal care services to CalOptima members may be subject to random drug testing. This shall include any employee who operates a CalOptima owned, or leased, motor vehicle.

All CalOptima employees ~~that~~ who have face-to-face interaction in the residence of a member, or prospective member, and provide health care services, or personal care services, such as nurses in the field, may be subject to random drug testing.

Employees are required to report any drug and/or alcohol related convictions occurring outside of the workplace to CalOptima within five (5) calendar days of such conviction. This information may subject the employee to corrective action, random testing requirements, referral to the Employee Assistance Program (EAP), and/or may be reported to the appropriate licensing authority.

See ~~Human Resources Policy~~CalOptima Policy GA.8052: Drug-Free and Alcohol-Free Workplace

# Employee Access to Personnel Records

Employees of CalOptima, in certain instances, are given permission to have access to information in their own personnel files. Employees may request access to this information at a reasonable time and place by appointment, usually during business hours in the Human Resources Department, unless another time or place is mutually agreed upon. CalOptima reserves the right to monitor the inspection of the file to ensure that nothing is removed, destroyed or altered, and that it is returned to its proper location. The right to inspection does not include certain records including, but not limited to, records relating to investigations, letters of reference, and/or records obtained prior to the employee's employment, or were obtained in connection with a promotion, or transfer. Employees requesting access to ~~his or her~~their own personnel record may review such records during ~~his or~~

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~~her~~their own personal time, either during scheduled break times, lunch, prior to or at the end of ~~the employee's~~employees' work days, or on ~~the~~ employees' ~~employee's~~ scheduled days off, depending on the availability of the Human Resources Department.

## Change of Employee Personal Information

Each employee is required to report promptly any change in his or her ~~his/her~~ status and/or personal information to the Human Resources Department as soon as it occurs, but in no event beyond thirty (30) calendar days. Such changes include name, address, marital status, telephone number, number of dependents, person(s) to be notified in case of emergency, physical limitations, beneficiary, etc. This information may affect deductions, health coverage, and many other aspects of employment. Status changes may be made through the Employee Self-Service module on the CalOptima InfoNet.

It is vitally important to notify the Human Resources Department within thirty (30) calendar days of a status change such as marriage, divorce, birth or adoption of a child. Notification and requests to add/delete dependents must be submitted in writing to the Human Resources Department. Failure to notify Human Resources of these qualifying events may preclude, or delay, changes in eligibility for insurance.

## Confidential Information

~~CalOptima property includes not only tangible property, like desks, file cabinets and computers, but also intangible property such as information.~~ CalOptima has a particular interest in protecting its proprietary, private, and/or confidential information. CalOptima property includes not only tangible property, like desks, file cabinets and computers, but also intangible property such as information. Proprietary information includes all information obtained by CalOptima employees during the course of their work including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel review, or social security number. Confidential information is any CalOptima information that is not known generally to the public including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, DHCS reimbursements, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

CalOptima employees, or agents, may not reveal, ~~or~~ disclose, divulge, or make accessible, proprietary, private, and/or confidential information belonging to, or obtained through, the employee's affiliation with CalOptima to any person, including relatives, friends, and business and professional associates, other than persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. Employees may not disclose or use proprietary, or confidential, information, except as their jobs require. Inappropriate use, unauthorized copy and transfer, attempted destruction, the destruction or disclosure of confidential, private, or proprietary information obtained through the employee's affiliation with CalOptima will subject an employee to corrective action, up to and including termination and possible legal recourse.

*Confidentiality and the Health Insurance Portability and Accountability Act (HIPAA)*
CalOptima is committed to protecting the confidential, sensitive, and proprietary health information of our members and employees. HIPAA addresses the ~~our~~ need to protect and safeguard our members' information. This includes making sure electronic health information is secure, taking precautions to safeguard member files, and following all other HIPAA regulations regarding Protected Health Information (PHI).

An employee should not store PHI on CDs, DVDs, external electronic storage devices, mobile phones, external email accounts and cloud storage without proper authorization from the Information Services (IS) Department. Also, s*ensitive data such as PHI should not be stored on nor sent to, from or through any employee's personal consumer email service. Examples include Yahoo!, live.com, Gmail, Hotmail, AOL, or any other non-CalOptima email system.*

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Please contact our Privacy Officer for more information. Failure to follow HIPAA regulations and CalOptima policies concerning protection of member and employee files and information may subject an employee to corrective action up to and including termination and possible legal recourse.

See ~~Human Resources Policy~~CalOptima Policies GA.8050: Confidentiality, ~~ISInformation ServicespP;~~ ~~IS.1101: EPHI Physical Controls,~~GA.5005a: Use of Technology Resources, IS.1201: -Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls, IS.1202: -Electronic Protected Health Information (EPHI) ~~EPHI~~ Technical Safeguards - Data Controls, ~~GA.5005a: Use of Technology Resources,~~ and IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI).
~~IS Policy GA.5005a: Use of Technology Resources; and IS Policy IS.1102: Electronic Media, Electronic Storage Device, and Hardware Controls.~~

# Compliance Program

CalOptima maintains a comprehensive Compliance Program, part of which is a plan to detect, investigate, and report fraud, waste, and abuse in any and all of the CalOptima programs. CalOptima employees are required to report any and all suspected, or actual, cases of fraud, waste, and abuse to the CalOptima Office of Compliance. An employee can file a report anonymously by contacting the CalOptima Compliance and Ethics Hotline at 1-877-837-4417. Employees can also file a Suspected Fraud or Abuse Referral Form with the Office of Compliance, which is available on the CalOptima InfoNet. In addition, employees are always welcome to speak with their supervisor or the Compliance Officer at any time with any concerns they may have. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation protections.

The CalOptima Code of Conduct provides that CalOptima employees are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to any CalOptima program, its policies and procedures, and its Compliance program. Failure to comply with the Compliance program, including CalOptima's Code of Conduct, may lead to disciplinary action. Discipline, at CalOptima's discretion, may include corrective action or may lead to direct termination in accordance with CalOptima policies. In addition, failure to comply with CalOptima's Compliance Program and Code of Conduct may result in the imposition of civil, criminal, or administrative fines on the employee and/or CalOptima, which may include exclusion from participation in federal and/or state health care programs.

See CalOptimaOffice of Compliance Policiesy HH.2014Δ: Compliance Program and
See Office of Compliance Policy HH.2028Δ: Code of Conduct

# Code of Conduct

CalOptima maintains a strict Code of Conduct governing employee conduct, as well as ethical behavior related to and/or concerning work-related decisions. CalOptima expects all employees to follow this code and to report situations in which they become aware of circumstances and/or behaviors which do not live up to CalOptima's standard. In order to discourage inappropriate conduct and/or illegal activities and to protect member confidentiality, CalOptima maintains the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 to provide an opportunity for all employees to report unethical conduct. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation protections.

The CalOptima Code of Conduct provides that CalOptima employees are encouraged to speak up and report any instance in which unethical behavior occurs as outlined in the Code of Conduct policy. Failure to comply with the Code of Conduct may lead to corrective action, up to and including termination.

See CalOptima's Code of Conduct

# Dress Code

CalOptima has adopted a Business Casual Attire Dress policy as the standard attire from Monday through Thursday. Employees must choose business casual clothing that communicates professionalism. Business casual includes CalOptima logo attire.

There may be times that management may require employees to dress in customary business professional attire including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the organization at an outside community function.

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The following dress guideline outlines the general workplace standard that must be followed by CalOptima employees. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees based upon job duties.

**Business Casual**: Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be compatible with a professional environment and clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards, and no more than three and one-half (3 ½) inches in height. In all cases, management within each respective department will define "appropriate" business casual attire.

When dressing in business casual, we ask that employees not wear jeans (or any type of denim or any color jeans or overalls), spaghetti strap shirts casual tank tops, halter tops or tube tops, see-through clothing, short skirts (where the length and/or fit is incompatible with a professional environment), any type of shorts, casual sandals (such as flip flops, slide sandals or beach attire), tennis or canvas shoes, any footwear without a back or backstrap, capri pants (unless part of a professional dress suit or two-piece business outfit), leggings or stretch pants, clothing displaying any written words or symbols (with the exception of CalOptima logo attire, or brand names, or symbols), clothing that reveals undergarments or parts of the body incompatible with a professional setting, or any type of hat, unless the employee obtains prior approval from Human Resources.

**CalOptima Logo Attire** (Monday–Friday): CalOptima logo attire includes sweaters, dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants, or khaki pants, in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans or capri pants from Monday through Thursday.

**Casual Attire** (Friday): Casual attire is a benefit permitted only on Fridays, unless otherwise specified. As with business casual attire, casual attire should be compatible with a professional environment and neat in appearance and in good repair, with no tears, or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals with a backstrap, tennis shoes, or other casual clothing in good condition. Leggings are acceptable only when worn with a dress, or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire.

Casual attire does not include: any type of jogging or sweat suits/sweatpants; spaghetti strap tops, casual tank tops, halter tops, or tube tops; casual sandals (such as flip flops, slide sandals, or beach attire); any footwear without a back or backstrap; house slippers; yoga or workout pants; see-through clothing; ripped jeans (including shredded jeans); any type of shorts; clothing that exposes the stomach area or other parts of the body incompatible with a professional environment; clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos; or hats, unless prior approval from Human Resources is given.

As a benefit, employees may dress in casual attire every Friday and every year during the following times, unless otherwise specified:

- The week of Thanksgiving;
- The period between Christmas and New Year's Day;
- The period between Memorial Day and Labor Day; and
- National Customer Service Week (First week of October).

Employees may be subject to corrective action, up to and including termination, for violations of CalOptima's dress code policy.

See CalOptima Policy GA.8032: Employee Dress Code

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~~See Human Resources Policy GA.8032: Employee Dress Code~~

## Conflict of Interest

Employees are expected to devote their best efforts and attention to the full-time performance of their jobs. Employees are expected to use good judgment, to adhere to high ethical standards, and to avoid situations that create an actual or potential conflict or the appearance of a conflict between the employee's personal interests and the interests of CalOptima. ~~It is CalOptima's view that both the actual and appearance of a conflict of interest must be avoided.~~

Employees unsure as to whether a certain personal or non-CalOptima transaction, activity, or relationship constitutes a conflict of interest should discuss it with their immediate supervisor, or the Human Resources Department for clarification. Any exceptions to this guideline must be approved, in writing, by CalOptima's Chief Executive Officer (CEO).

While it is not feasible to describe all possible conflicts of interest that could develop, some of the more common actual, or potential, conflicts, which employees should avoid, include the following:

1. Accepting personal gifts or entertainment from current or potential providers, members, or suppliers ~~that is more than~~ totaling more than five dollars ($5) ~~in twenty-five dollars ($25)~~ in a calendar year from any single source;
2. Working for a current or potential provider, contractor, vendor, member, or supplier, association of contractors, vendors, providers, or other organizations with which CalOptima does business or which seek to do business with CalOptima, except when it is determined that the nature of the job does not create a conflict;
3. Engaging in self-employment in competition with CalOptima;
4. Using proprietary or confidential CalOptima information for personal gain, or the gain of others, or CalOptima's detriment;
5. Having a direct or indirect financial interest in or relationship with a current or potential provider, supplier, or member; except when it is determined that the nature or financial interest does not create a conflict
6. Using CalOptima assets or labor for personal use;
7. Acquiring any interest in property or assets of any kind for the purpose of selling or leasing it to CalOptima; and/or
8. Committing CalOptima to give its financial, or other, support to any outside activity, or organization.

If an employee, or someone with whom an employee has a close relationship (a family member or close companion), has a financial, or employment, relationship with a current, or potential, provider, contractor, vendor, supplier, or member, the employee must disclose this fact in writing to the Human Resources Department. Employees should be aware that if they enter into a personal relationship with an employee of a current, or potential provider, supplier, or member, a conflict of interest might exist, which requires full disclosure to CalOptima.

All CalOptima employees are required to promptly report any and all non-CalOptima job positions, positions held on non-profit/charitable organizations, and/or their affiliations or interests in job-related businesses, or organizations to the Human Resources Department.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Supplement to Form 700 upon hire, annually, and upon termination of employment. The Human Resources Department coordinates this activity with the Clerk of the CalOptima Board.

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Failure to adhere to this guideline, including failure to disclose any outside positions, conflicts or to seek an exception, may result in corrective action, up to and including termination of employment and/or criminal, civil, or administrative action.

See Human Resources PolicyCalOptima Policies GA.8012: Conflicts of Interest, Pp AA.1204: Gifts, Honoraria, and Travel Payments, and P AA.1216: CalOptima Solicitation and Receipt of Gifts to CalOptima.

## Guests

Due to the confidential nature of CalOptima's operations, employees are discouraged from having visitors at work, unless necessary, or related to performance of job duties. Children of employees are not allowed on the premises during working hours unless attending a formal CalOptima sponsored function or unless previously authorized by the employee's management during the employee's non-working hours (*e.g.*, lunch break, PTO day off, etc.).

All guests must register at the reception desk in the lobby and obtain a guest badge. Guests are not permitted to walk around CalOptima's secured areas unaccompanied. Employees shall not permit guests to access CalOptima facilities for any unauthorized purpose and/or to perform personal business, unless as part of a formal CalOptima sponsored function.

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# Introduction

CalOptima is proud of the comprehensive benefits package we provide to our employees. This section of the handbook is designed to acquaint employees with some of the more significant features of CalOptima's employee benefits. It is important to remember that more detailed information is set forth in the official plan documents, summary plans descriptions and/or group policy contracts that govern the plans. Accordingly, if there is any real or apparent conflict between the brief summaries contained in this manual and the terms, conditions, limitations or exclusions of the official plan documents, the provisions of the official plan documents will control over these brief summaries. Employees are welcome and encouraged to review the official plan documents, available in the Human Resources Department, for further information.

# Workers' Compensation

CalOptima, in accordance with state law, provides insurance coverage for employees in case of work-related injuries. The cost of this insurance is completely paid for by CalOptima. The Workers' Compensation benefits provided to injured employees may include:

- Medical, surgical, and hospital treatment;
- Partial payment for lost earnings that result from work-related injuries; and/or
- Rehabilitation services to help injured employees return to a suitable employment.

Workers' Compensation is a type of accident and injury insurance that compensates an employee for lost wages, medical expenses and permanent impairment as a result of a work-related injury or illness. Injured or ill employees are entitled to receive the following benefits -when they sustain an injury or illness "arising out of and in the course of their employment":

- Medical Care,
- Temporary Disability Benefits,
- Permanent Disability Benefits,
- Supplemental Job Displacement Benefits if they are not able to return to their regular work; and/or
- ~~and/or~~ Death Benefits.

When an employee reports a work-related injury or illness, he or she will be sent to a designated clinic within the Medical Provider Network (MPN) set up by our workers' compensation carrier. Employees may see their own doctor only if their doctor has previously been designated as the treating physician and this authorization has been submitted to Human Resources at least 30 days prior to an injury or onset of illness. All appointments related to medical treatment must be coordinated through the Workers' Compensation insurance company and the Human Resources Department.

Temporary disability benefits are payments for lost wages that are paid to the injured or ill employee while they are recovering and are unable to work. Temporary disability benefits are based on 2/3 of the employee's average weekly earnings up to a statutory cap (set by the State legislature). They are paid every 14 days for a total of 104 weeks maximum. No payments are made for the first 3 days (waiting period) unless the disability continues for more than 14 calendar days, the employee is hospitalized or is the victim of a criminal assault. Paid Time Off (PTO) may be used for the 3–day waiting period.

Employees are required to report all on-the-job injuries to their supervisor and Human Resources immediately, regardless of how minor the injury may be. Managers who are aware of a workplace injury or illness are required to notify Human Resources immediately. CalOptima is legally required to report serious injuries, or illnesses, including the death of an employee, within eight (8) hours of the incident and/or accident.

See ~~Human Resources Policy~~CalOptima Policy GA.8041: Workers' Compensation Leave of Absence

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# Paid Time Off and Workers' Compensation

Workers' Compensation does not usually cover absences for medical treatment, follow-up doctor's appointments, physical therapy appointments, and/or other appointments related to a Workers' Compensation claim, or injury. Employees returning to work, or who are still working after a work-related injury or illness under the Workers' Compensation Act, are required to coordinate with their supervisor to use accrued PTO, or make up time away from work, consistent with CalOptima's timekeeping requirements, for follow-up medical appointments. Appointments should be scheduled in a manner that provides the least disruption to the employee's normal work schedule. Injured or ill employees are encouraged to document all mileage incurred for medical appointments and submit to the workers' compensation carrier for reimbursement. Employees who do not have sufficient PTO accruals may take unpaid time off for follow-up medical appointments. ~~Any further medical treatment will be under the direction of the employee's primary treating physician. Employees~~

# Core Health Benefits

The benefits CalOptima offers its employees are an important part of a total compensation package. Such benefits, like health and life insurance, would be significantly more expensive if employees had to purchase them privately. CalOptima's benefits are regularly reviewed to ensure that they are competitive with those offered by other public agencies and organizations in Southern California.

All regular full-time, regular part-time, and qualifying as-needed employees and, if elected, their eligible family members, are eligible for health insurance benefits beginning the first day of the month following the employee's date of hire. However, if the date of hire is on the first of the month, health insurance benefits begin effective on the hire date. Eligible family members include: spouses, registered domestic partners, and dependent children under the age of twenty-six (26), or disabled dependent. Documentation certifying eligibility is required. Coverage will commence on the first (1st) of the month following the employee's date of hire unless the date of hire is the first (1st) of the month.

Employment eligibility requirements and enrollment change information is available in the individual Summary of Benefits and Coverage (SBC), Summary Plan Descriptions (SPD), and other benefits booklets. Questions regarding any of CalOptima's benefits should be directed to the Human Resources Department.

Once enrolled, the employee's elections will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Many of the deductions taken on CalOptima employee health benefits are taken on a pre-tax basis since CalOptima participates in a Flexible Benefits Plan (Cafeteria Section 125 Plan). Unless the employee has a qualifying event, no changes can be made to the employee's elections after the open enrollment period has ended. Employees are solely responsible for making sure the employee's elections are accurate. For this reason, changes to medical, dental, vision, health, or dependent care flexible spending accounts (FSA) may only be made with the submission of supporting documentation that provides substantiation of the qualifying event. Some examples of qualifying events include, but are not limited ~~to:~~to marriage, divorce, birth/adoption of child, over-age dependent, and change of spouse's employment. If one of these events occurs, the Human Resources Department must be contacted within thirty (30) days to make a change. Otherwise, employees are required to wait until the next annual open enrollment period, usually held in October of each year, to make any changes to their elections. The effective date for qualifying event changes can only be made prospectively, not retroactively.

When health benefits coverage terminates due to an extended personal leave of absence, or termination of employment with CalOptima, employees may be eligible under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) to continue enrollment for a period of time. Additional information is mailed to terminated employees from a third-party COBRA administrator following the last day of employment.

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Upon an employee's separation from CalOptima, health insurance benefits continue through the end of the month that he or she terminates in. The employee is responsible for his or her share of the costs for health insurance benefits for the entire month, and appropriate deductions will be included in the employee's final paycheck.

Below is a list of core benefits available to eligible full-time and part-time regular employees. The employee premiums, deductions from payroll for these benefits, vary depending on the employee's employment classification and annual modifications based on changes in premiums from our carriers. CalOptima reserves the rights to modify, change, eliminate, or add to the following list of benefits at ~~it~~its sole discretion:

**Health —** CalOptima provides different options for affordable HMO and PPO health plans that include a broad network of medical groups and hospital access with a very reasonable co-pay structure for office visits and pharmacy benefits. A High Deduction Health Plan (HDHP), inclusive of employer contributions, and a Health Savings Account (HSA) are available at the employee's election.

**Dental** — Comprehensive dental plans that include services such as orthodontia benefits and preventive dental care visits ~~at no charge, as well as orthodontia benefits,~~ are available to CalOptima employees.

**Vision** — CalOptima's vision plan design allows for eye examinations, glasses, and contact lenses.

**Life and AD&D** — Full-time regular employees receive a $50,000 life and accidental death and dismemberment (AD&D) insurance policy, or one (1) times the employee's basic annual earnings, whichever is higher, with a maximum amount of $~~325~~400,000. Part-time regular employees receive a $25,000 life and AD&D insurance policy, or one (1) times their basic annual earnings, whichever is higher.

**Short-Term Disability** — An employee with a qualifying disability/condition may receive short-term disability benefits, which pays ~~sixty~~ seventy percent (~~6~~70%) of an employee's regular wages for a period of time following a waiting period. This benefit is a substitute for state disability benefits as CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

**Long-Term Disability** — An eligible employee with a qualifying disability/condition may receive long-term disability benefits, which pays sixty percent (60%) of regular wages until normal retirement age, as long as the employee meets the definition of disability. This benefit is used in lieu of state disability benefits since CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

**Employee Assistance Program (EAP)** — This free and confidential resource provides easy and accessible services to employees (and some extended family members) for behavioral health issues such as: counseling for relationship issues, emotional well-being, legal and financial assistance, substance abuse, as well as workplace challenges.

CalOptima also offers additional voluntary benefits to eligible employees. These voluntary optional benefits may include benefits such as: additional voluntary life and AD&D insurance, whole life and critical illness insurance plans, legal plans, and flexible spending accounts (FSA). All voluntary benefit premiums are one hundred percent (100%) paid for by the employee.

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## Retirement Benefits

**CalPERS (California Public Employees Retirement System) Defined Benefit Plan** — CalOptima has contracted with CalPERS instead of participating in Social Security. Regular full-time and regular part-time employees are automatically enrolled into the CalPERS plan upon date of eligibility, which is usually the employee's date of hire. In particular cases, qualifying as-needed and temporary employees, who were previously enrolled in CalPERS may also be enrolled into CalPERS upon date of eligibility. To be eligible for service

retirement with CalPERS, employees considered classic CalPERS members must be at least age fifty (50) and have a minimum of five (5) years credited service. For new employees hired on, or after, December 1, 2013, who do not have reciprocal rights, the minimum retirement age for new hires has been increased to fifty-two (52); however, the years of credited service remains five (5). Classic CalPERS members (those that established membership prior to January 1, 2013) are enrolled in the 2 percent @ 60 benefit formula. New members (those that established membership on or after January 1, 2013) are enrolled in the 2 percent @ 62 formula. Basic CalPERS plan information is provided to employees during their first month of employment.

**PARS (Public Agency Retirement Services) Defined Contribution Plan** — This supplemental retirement plan is a 401(a) tax-qualified multiple employer trust. All regular full-time and regular part-time employees are automatically enrolled, and a contribution is made by CalOptima. There is a vesting requirement based on quarters of service. Contributions are automatically invested into a life-cycle mutual fund and professionally managed; however, employees have the option to self-direct fund investments in their account. Basic plan information is provided to employees during their first month of employment.

**457b Deferred Compensation Plan** — A 457b voluntary plan is also offered as a way to save for retirement. All deposits to this plan are made by the employee. The annual IRS regulated contribution limit generally increases each year and catch-up contribution provisions are available for those who are age fifty (50) and above. The employee determines his or her contribution amount as well as his or her investment allocation. A licensed financial advisor will provide plan related information, usually within the first month of employment.

**Social Security Retirement** — CalOptima does not participate in Social Security. All regular full-time and regular part-time employees are considered Social Security tax exempt and pay into CalPERS instead of Social Security. Upon hire, Human Resources will explain how CalPERS and Social Security work together. The Human Resources Department will inform employees about two (2) important Social Security provisions: Government Pension Offset and Windfall Elimination Provision. As-needed employees are not eligible for CalPERS membership, unless certain conditions apply, therefore, by default, unless they are eligible for enrollment in CalPERS, they are the exception to this rule and will see a FICA/Social Security deduction taken from their payroll, and subsequently are only authorized to work up to one thousand (1,000) hours per fiscal year on a general basis.

**Medicare** — The employee and CalOptima each contribute their proportionate share to Medicare.

# Paid Time Off (PTO)

CalOptima provides paid time off (PTO) benefits to all eligible employees to enable them to take time off from work for activities such as rest, recreation, recovery from injury and illness or other personal activities ~~for rest and recreation and to recover from illness.~~ CalOptima believes this time is valuable for employees in order to enhance productivity and to make the work experience more personally satisfying. CalOptima provides ~~long-service~~ employees with additional hours of PTO ~~benefits~~ as years of service are accumulated.

Full-time, part-time, and limited-term employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use PTO hours for vacation, preventive health or dental care, or care of an existing health condition of the employee, or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, Child-Related Activities, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. CalOptima encourages all employees to maintain a work-life balance by utilizing PTO benefits for rest and recreation throughout the year.

When available PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's annual PTO accrual rate. When an employee reaches his or her maximum PTO accrual amount, the employee will stop

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accruing PTO. ~~PTO accruals will only accrue in conjunction with CalOptima payroll and will be prorated based on hours earned.~~ Each year each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year.

Eligible employees accrue PTO based on their classification as exempt, or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and years of continuous services in accordance with the ~~following~~ accrual schedule below. PTO begins accruing from the date of hire. PTO accruals will only accrue in conjunction with CalOptima payroll and will be prorated based on hours earned.

**Annual Paid Time Off Benefits Accrual Schedule**

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period.

**Non-Exempt Employees:**

| Years of Continuous Service | Hours of PTO ~~Earned~~ Accrued (Biweekly pay period) | Annual Hourly Accrual ~~Hours Accrued per Year~~ | Days Accrued per Year |
|---|---|---|---|
| 0–3 | 5.54 | 144 | 18 |
| 4–10 | 7.08 | 184 | 23 |
| 11 + | 8.62 | 224 | 28 |

**Exempt Employees:**

| Years of Continuous Service | Hours of PTO ~~Earned~~ Accrued (Biweekly pay period) | Annual Hourly Accrual ~~Hours Accrued per Year~~ | Days Accrued per Year |
|---|---|---|---|
| 0–3 | 7.08 | 184 | 23 |
| 4–10 | 8.62 | 224 | 28 |
| 11 + | 10.15 | 264 | 33 |

Scheduling of PTO is to be done in a manner compatible with CalOptima's operational requirements. In order to minimize the impact of an employee's absence, planned time off- should be submitted by an employee to his or her immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO.

PTO Donation Program: ~~At the discretion of the~~The Human Resources Department administers~~,~~ a PTO Donation Program ~~may be implemented~~. Employees may donate accrued PTO hours to assist another CalOptima employee ("Recipient Employee") when a Recipient Employee qualifies as having a Catastrophic Illness. Donations are ~~completely~~ voluntary and donors will remain anonymous to the Recipient Employee.

See ~~Human Resources Policy~~CalOptima Policy GA.8018: Paid Time Off (PTO)

## Paid Sick Leave

CalOptima provides employees who are eligible to accrue PTO a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Healthy Workplaces, Healthy Families Act of 2014 (Act)~~.~~, effective July 1, 2015. For all other employees who are not eligible to accrue PTO~~, effective July 1, 2015~~, as-needed, per diem, or temporary employees may become eligible for paid sick leave if the employee works thirty (30), or more, days within one (1) year from the start of their date of employment. Twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave is provided only to eligible employees who do not accrue PTO.

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Upon satisfying a ninety (90)-day employment period, employees may use accrued sick leave for preventative care or diagnosis, care, or treatment of an existing health condition of the employee, or the employee's family member, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

Upon termination, resignation, retirement, or other separation from employment, CalOptima will not pay out employees for unused paid sick leave time accrued under the Act. If an employee separates and is then rehired by CalOptima within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Act's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

See ~~Human Resources Policy~~CalOptima Policy GA. 8018: Paid Time Off (PTO)

## Holidays

CalOptima generally observes the following holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day and the Friday after Thanksgiving
- Christmas Day
- One (1) Flex Day (accrues on January 1st)

A holiday that falls on a Saturday or Sunday is usually observed on the preceding Friday, or the following Monday. Holiday observances will be announced in advance. CalOptima may, in its discretion, require an employee to work on scheduled holidays. If a non-exempt employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday pay in addition to his or her regular compensation for the hours of actual work performed. From time to time, at the discretion of the CEO, the CEO, or his or her ~~his/her~~ designee, may authorize managers, at their discretion, to release employees early, up to a maximum of two (2) hours, with pay, on the work day immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of employees early is intended to benefit only those employees who are working on the work day immediately preceding a holiday. Employees who are on PTO on the day employees are permitted to leave early are not entitled to any credit or future early release.

**Flex Holidays**

Employees will receive a maximum of one (1) flex holiday (maximum of eight (8) hours, prorated based on scheduled work hours) on January 1st of each year; however, CalOptima reserves the right to assign a specific date for the flex holiday for business reasons and/or needs. Limits are imposed on the number of flex holiday hours that can be maintained in the employee's flex holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an employee's flex holiday account as of January 1st of each year. In the event that available flex holiday hours are not used by the last pay period of the calendar year, employees may carry unused flex holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on the scheduled work hours. If an employee reaches the maximum amount of twelve (12) hours on January 1st, prorated based on the scheduled work hours, the employee will stop accruing flex holiday hours. Flex holiday hours are not eligible for annual cash out applicable to PTO hours. However, if an employee separates from CalOptima and has unused flex holiday hours, the unused flex holiday hours for that

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1 calendar year will be paid out at the same time and in the same manner as unused PTO hours upon termination.
2
3 **Eligibility**
4
5 Regular full-time and regular part-time employees who are regularly scheduled to work twenty (20), or more,
6 hours per week are eligible for holiday benefits and flex holiday accrual ~~hours, but~~hours but will be prorated
7 based on their full-time or part-time status at the time of the holiday. To receive holiday pay, employees must
8 work, or be paid for the regularly scheduled workdays preceding and following the CalOptima holiday. If a paid
9 holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if
10 PTO is being used for the LOA the day before and the day after the holiday, and the holiday pay will be prorated
11 based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a
12 day in which the employee would have been regularly scheduled to work, the holiday will count against the
13 employee's LOA entitlement.
14
15 See ~~Human Resources Policy~~CalOptima Policy GA.8056: Paid Holidays
16
17

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# Education Reimbursement

CalOptima believes in the development and growth of its employees. In order to encourage developmental progression, CalOptima provides an Education Reimbursement Program to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements. Education Reimbursement is available to all eligible regular full-time, or part-time, employees who have completed their initial one hundred eighty (180) days of continuous employment, are in good standing, and are eligible to participate.

Courses eligible for tuition reimbursement must be either part of an accredited college degree program, or ~~individual local courses~~ provided by credible institutions that meet ~~one (1)~~ the following conditions:

1. Educate the employee in concepts and methods in their present assignment.
2. Help prepare the employee for advancement to other positions available within CalOptima.

Continuing education courses that provide credit towards renewal of a licensure and/or certification may be eligible for reimbursement under this policy. Seminars, conferences, or business meetings that do not result in certification or credit towards a licensure and/or certification are not covered. Seminars, conferences, and business meetings may be eligible for reimbursement through CalOptima's Travel and Training program. Effective July 1, 2019, the costs of new or renewed licensures or certifications are not covered under CalOptima Policy GA.8036: Education Reimbursement.

Attendance at outside education courses and/or programs, whether required by CalOptima, or requested by individual employees, requires prior written management and Human Resources approval. Details of the program and how to apply for reimbursement are available in the Human Resources Department. The Human Resources Department shall be responsible for developing, administering, and maintaining the program. In order to be reimbursed, eligible employees must satisfactorily complete a work-related course or program, or complete a professional certification offered by an accredited school, community college, college, university, or other recognized professional organization, or learning institution. Miscellaneous expenses such as parking, exams, education subscriptions, books, and supplies are not covered and shall not be reimbursed.

See ~~Human Resources Policy~~ CalOptima Policy GA.8036: Education Reimbursement

# COBRA

CalOptima complies with the provisions and requirements of both the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Both Acts provide for continued coverage of an employee's, his or her spouse's, and his or her dependents' health benefit coverage in the event that the employee is no longer eligible for CalOptima's group health coverage. Please see the Human Resources Department for additional information.

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19 **CalOptima Property**

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# Employer Property

Cubicles, desks, computers, vehicles, and other CalOptima owned, or leased, items are considered CalOptima property and must be maintained according to CalOptima's policies, rules, and regulations. CalOptima property must be kept clean and in good condition. Decorations in an employee's work space should fit with the overall professional business atmosphere CalOptima projects and should take into consideration the needs and sensitivities of our members, providers, fellow employees, and the public.

Data maintained on CalOptima's systems, including employee work-product, are CalOptima property, and employees should refrain from downloading any CalOptima work product, particularly confidential and proprietary information, including but not limited to, documents the employee may have developed or prepared that contain PHI, during the course of employment and/or upon termination. Potential civil and criminal liability may result from such conduct.

Posters, calendars, personal affects, etc. are not allowed to be taped, or tacked, to shared areas such as filing cabinets, corridors, walls, or doors. In addition, the placing of items outside of a work station panel is prohibited. If an employee has any items that need to be mounted on a wall within his or her workstation or office, he or she should request assistance from the Facilities Department. CalOptima reserves the right to inspect all CalOptima property to ensure compliance with its policies, rules, and regulations, without notice to the employee and at any time, not necessarily in the employee's presence.

Employees are asked to minimize personal phone calls and messages from personal callers to avoid interruption of work. CalOptima understands that, from time-to-time, personal, or family calls or messages, are necessary; however, employees are expected to use good judgment and, whenever possible, to limit these calls to meal and break times. CalOptima reserves the right to monitor voice mail messages and email messages to ensure compliance with this rule, without notice to the employee and at any time, not necessarily in the employee's presence. Employees should be aware that as a public agency, all documents, including email messages and instant messages, are public records and may be subject to disclosure. Employees should not have any expectation of privacy concerning email messages sent and received from CalOptima email or instant messages sent and received through CalOptima's network.

Communication through CalOptima systems, including, but not limited to, emails, facsimile and telephones, may be monitored or recorded, and employees should not have an expectation of privacy or confidentiality in communications made through CalOptima-owned equipment.

In the event that a telephone call ~~including, but not limited~~ to~~,~~ a member, provider, third-party or employee, or a virtual online presentation, meeting or educational session is to be recorded by CalOptima, ~~all persons must have knowledge of~~CalOptima employees will be responsible for notifying all parties about the recording. Participants may ~~and~~ consent to the recording, explicitly or implicitly by remaining on the call or presentation. T~~California law requires t~~o legally record a conversation, -all parties must be made aware of the recording and ~~in agreement~~consent, either explicitly or by continuing with the conversation after notice. Otherwise, in California, it is a criminal offense to use any device to record communications, whether they a're wire, oral or electronic, without the consent of everyone taking part in the communication.

Prior authorization must be obtained before any CalOptima property may be removed from the premises. For security reasons, employees should not leave personal belongings of value in the workplace or in plain view. Employees are solely responsible for their own personal belongings, and CalOptima shall not be liable for any lost, stolen or misplaced personal belongings. Personal items in and on CalOptima property are subject to reasonable inspection and search.

Terminated employees must remove any personal items at the time they leave CalOptima or make arrangements with Human Resources to remove these items. Personal items left in the workplace are subject to disposal if arrangements are not made at the time of an employee's termination. CalOptima shall not be responsible for any lost, or discarded, personal items left behind. Terminated employees who have CalOptima property at their home must make arrangements with Human Resources to have these items picked up within a week of their termination date.

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# Housekeeping

All employees are expected to keep their work areas clean and organized. The use of personal floor, or desktop heaters, coffee makers, and mini-refrigerators is not permitted in the cubicles.

People using common areas such as lunch rooms, locker rooms, conference rooms, and restrooms are expected to use appropriate and courteous etiquette including keeping the common areas sanitary and in a clean state for the next person to use. Clean shared equipment and touchable surfaces frequently. Employees should clean up immediately after meals and dispose of trash properly. Washing or sanitizing hands before and after using common areas, such as breakrooms, is encouraged. ~~CalOptima~~CalOptima encourages good health habits to prevent the spread of germs, colds, the flu, and other illnesses.

# Off-Duty Use of Facilities

Employees are prohibited from remaining on CalOptima premises or making personal use of CalOptima facilities while not on duty without prior permission from the Human Resources Department.

# Cell Phones

**Driving with Cell Phones:**
In the interest of the safety of our employees and other drivers, and in compliance with state laws, CalOptima employees are prohibited from using cell phones without a hands-free device and prohibited from text messaging and/or searching the internet while driving on CalOptima business and/or driving during CalOptima time. If an employee's job requires that he or she keep his or her cell phone turned on while he or she is driving, he or she must use a hands-free device and operate the vehicle safely. Cell phones may not be used under any circumstances or in any manner that would distract an employee from the duty to drive in a safe and non-negligent manner.

**Cell Phone Etiquette:**
We ask that employees are considerate of others when using a cell phone during work hours and while on duty. Appropriate phone etiquette includes putting phones on silent, or vibrate, mode to minimize disruptions, and minimizing text messaging and internet surfing during meetings. Employees should refrain from excessive use of personal hand-held devices during work hours and while on duty for non-job-related duties. Employees are asked to minimize personal cell phone calls and text messages or personal emails unrelated to CalOptima business on hand-held devices to avoid interruption of work. Employees are asked to refrain from using cell phones in restrooms. Employees are expected to use good judgment and, whenever possible, to limit these personal cell phone calls or use of hand-held devices to meal and break times.

# Restrictions on Smoking and Unregulated Nicotine Products

As a public agency providing access to quality health care services, CalOptima endeavors to maintain a safe and healthful environment for its employees, members, and visitors to CalOptima property. In keeping with this philosophy, it is important that the workplace and office environment reflect CalOptima's concern for good health. Therefore, smoking, inclusive of electronic smoking devices, and the use of unregulated nicotine products is strictly prohibited inside the building and is allowed only in designated outside smoking areas at least twenty-five (25) feet away from any CalOptima owned, or leased, building. Employees who wish to smoke, inclusive of electronic smoking devices, or use unregulated nicotine products, must limit their smoking or use of unregulated nicotine products to break and meal periods in areas outside of work premises and only in designated smoking areas.

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See CalOptima Policy GA.8048: Restrictions on Smoking and Unregulated Nicotine Products

## Computer, Email, and Internet Usage

CalOptima recognizes that use of the Internet has many benefits for CalOptima and its employees. The Internet and email make communication more efficient and effective. Therefore, employees are encouraged to use and access the Internet appropriately. Unacceptable use of the Internet and email can place CalOptima and others at risk. As a public agency, we must be mindful that our written communications, stored data, and internet searches could constitute a public record. Therefore, all communications, including emails, and internet usage should be business appropriate.

The following guidelines have been established for using the Internet and email in an appropriate, ethical, and professional manner:

- CalOptima's Internet and email access may not be used for transmitting, retrieving, or storing of any communications of a defamatory, discriminatory, or harassing nature, or materials that are obscene, sexually suggestive, or explicit.
- No messages with derogatory, or inflammatory, remarks about an individual's race, age, disability, religion, national origin, physical attributes, or sexual preference shall be transmitted. Harassment and discrimination of any kind or form is strictly prohibited.
- Disparaging, abusive, profane, discriminatory, or offensive language and any illegal activities are forbidden. The posting, uploading, or downloading of pornographic or vulgar messages, photos, images, sound files, text files, video files, newsletters, or related materials is strictly prohibited.
- Each employee is responsible for the content of all text, audio, or images that he or she places or sends over CalOptima's Internet and email system. No email, or other electronic communications, may be sent that hides the identity of the sender or represents the sender as someone else.
- All CalOptima business should be conducted using CalOptima equipment and systems. CalOptima employees do not have access to personal email accounts over the internet. Access from work computers to consumer email services such as Google Gmail, Yahoo! Mail, AOL, Hotmail, live.com, EarthLink, university email systems, cable provider email systems, etc. is not available. Emails that are received from these services from members, providers, or others are permitted
- Users shall have no expectation or assumption of confidentiality, or privacy, of any kind related to the use of emails and the Internet. CalOptima has the right, with or without cause or notice, to access, examine, monitor, and regulate all electronic communications, including email messages, directories and files, as well as Internet usage. Also, the Internet is not secure, so employees should not assume that others cannot read, or possibly alter messages.
- Internal and external email messages are considered business records and may be subject to discovery in the event of litigation, or disclosure, in the event of a public records request. Be aware of this possibility when sending email within and outside CalOptima.
- Users shall ensure the security of Protected Health Information (PHI) in accordance with CalOptima's HIPAA policies. Sensitive data (PHI) should not be stored on nor sent to through any employee's personal consumer email services. Examples include Yahoo!, live.com, Gmail, Hotmail, AOL, or any other non-CalOptima email system.
- Users shall be responsible for using the Internet, email, InfoNet, and internal office communicator in an appropriate manner. CalOptima shall block access to categories of websites deemed inappropriate (illegal, pornographic, etc.) or unnecessary (entertainment, games, etc.).

All CalOptima-supplied technology, including computer systems and CalOptima-related work records, belong to CalOptima and not the employee. CalOptima may routinely monitor usage patterns for its email and Internet communications. Since all the computer systems and software, as well as the email and Internet connection, are CalOptima owned, all CalOptima policies are in effect at all times during usage. Any employee who abuses the privilege of access to email and/or the Internet may be denied access to the Internet and, if appropriate, be subject

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to corrective action up to and including termination.

CalOptima may periodically need to assign and/or change passwords and personal codes for voice mail, email, or computer login. CalOptima reserves the right to keep a record of all passwords and codes used for CalOptima business and/or may be able to override any such password system.

CalOptima has separate agreements with wireless providers. As a result, CalOptima employees may be eligible for discounts with these providers. Please check with Human Resources for more information.

See ~~Administrative~~ CalOptima Policies GA.5005a: Use of Technology Resources, ~~and~~ GA.5005b: E-mail and Internet Use and ~~Privacy Policy~~ HH.3014Δ: Use of Electronic Mail with Protected Health Information

## Solicitation, Distribution, and Bulletin Boards

CalOptima is an employer that values families and nonprofit organizations, and we want to support our employees with their fundraising activities. Employees should reserve fundraising activities for non-work time (breaks and lunch, or after hours) and in non-work areas (break rooms). Solicitations should be discrete, courteous, and carried out in a manner that does not interfere with CalOptima's operations. Please make sure that any solicitation involves requests that are professional and in good taste.

An employee may distribute, or circulate, non-CalOptima written materials to other employees only during non-working time and only in non-work areas. If an employee is unclear whether an area is a work, or non-work, area, he or she should consult his or her immediate supervisor or the Human Resources Department for clarification.

Solicitation, or distribution, in any way connected with the sale of any goods or services for profit is strictly prohibited anywhere on CalOptima property at any time, unless otherwise approved by management. Similarly, solicitation, or distribution, of literature for any purpose by non-employees is strictly prohibited on CalOptima's property at any time.

CalOptima has a bulletin board located on each floor for the purpose of communicating with its employees. Postings on these boards are limited to CalOptima related material including statutory and legal notices, safety and work-related rules, CalOptima policies, memos of general interest relating to CalOptima and other items. All postings require the prior approval of the Human Resources Director, or designee.

Unauthorized posting of literature on CalOptima property (including bulletin boards, walls, and the outside of cubicles) is strictly prohibited.

## Photo-Identification Badges

Employees of CalOptima are required to wear their photo-identification badges while at CalOptima and, when appropriate, while conducting CalOptima business. Photo identification badges must be visible at all times while working on site. In addition, an employee's photo-identification badge also serves as a key to allow an employee access to the entrance of the building, his or her department, restrooms, break/lunch room, and other permitted areas within the building.

Photo-identification badges and/or key cards are not transferable to other CalOptima employees, vendors, or family members.

The employee's photo-identification badge is the property of CalOptima and must be returned when employment is terminated for any reason.

We also encourage employees to be aware of people in our work areas to make sure they are wearing a badge and

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1 are either CalOptima employees or escorted by CalOptima employees. If an employee notices someone who is not
2 wearing a ~~badge~~badge, they are expected to report them to the Facilities Department.

# Wages and Work Schedules

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# Work Schedules

CalOptima's normal hours of operation are between the hours of 8 a.m. and 5 p.m., Monday through Friday, and our reception area is open during these hours. You and your supervisor will work out your individual work schedule, meal period, and break times. All employees are expected to be at their desks, or work stations, at the start of their scheduled shifts, ready to work. CalOptima reserves the right to modify employees' starting and ending times and the number of hours worked.

# Timekeeping Requirements

Efficient business operations depend on the reliability of all employees. CalOptima employees are required to follow established guidelines for recording their hours worked.

All hourly (non-exempt) employees are required to accurately record time in CalOptima's timekeeping system. Hourly employees must record their own time by clocking in at the start of the scheduled shift and clocking out at the end of their scheduled shift, as well as clocking out at the beginning of their scheduled meal break and clocking in at the end of their scheduled meal break on a daily basis. Except for scheduled break times, hourly employees also must record their time away from CalOptima premises whenever they leave the building for any reason other than CalOptima business. Hourly (non-exempt) employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks.

Clocking in/out for another employee or having another employee clock in/out for the employee constitutes falsification of timekeeping records and is grounds for immediate termination for one (1) or both employees, depending on the circumstances. Hourly employees who consistently fail to accurately and timely clock in/out may receive corrective action, up to and including termination of employment.

It is the responsibility of each employee to verify and approve their time worked as recorded in CalOptima's timekeeping system. Any errors on an employee's time record should be reported immediately to his or her immediate supervisor. By submitting the time sheet each payroll cycle, the employee is representing that the time worked accurately reflects any and all time the employee worked during that pay period.

Supervisors will determine and notify employees of their regular work schedule/shift. Due to possible changes in work force and CalOptima's needs, CalOptima retains the right to change an employee's work schedule, or the number of hours worked in a day, subject to all applicable wage and hour laws.

When business requirements or other needs cannot be met during regular working hours, employees may be scheduled to work overtime hours. Hourly (non-exempt) employees will receive overtime pay for any overtime hours worked. Hourly (non-exempt) employees may NOT work overtime without prior ~~written~~ authorization from their immediate supervisor. Hourly employees are not permitted to start work early, finish work late, work during meal periods, take work home, work on weekends, or perform any other unauthorized extra and/or overtime work without prior authorization from their immediate supervisor. Hourly employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks.

Salaried (exempt) employees are not required to complete timecards and are not eligible for overtime. However, as a public agency employer, CalOptima has expectations of employees that are established pursuant to principles of public accountability. Exempt employees are expected to work a regular work schedule based on CalOptima's core business hours and should notify their supervisors in advance of any deviations from their normal work schedule and accurately record any exceptions to their regular work schedule including, but not limited to, hours used for PTO, jury duty, bereavement leave, etc.

CalOptima looks to salaried employees to demonstrate the level of commitment and conscientiousness that is appropriate to their status. Salaried employees work a minimum of eighty (80) hours per pay period (for full-time employees) and may need to work additional hours to complete projects and tasks. Salaried employees are not

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eligible for overtime payment but may be asked to work additional hours when business needs require. CalOptima does not provide "comp time" to ~~non-salaried~~non-salary or salaried employees for hours worked beyond the forty (40)-hour workweek.

Subject to the supervisor's prior approval, a salaried employee may request a partial day absence (for example, two (2) hours for a doctor's appointment). When an occasional, short-term scheduled absence for a partial day occurs the salaried employee may make up time away from work within the same pay period or use accrued PTO if the employee does not otherwise make up the time off within the same pay period. If the employee has exhausted ~~all of~~all his or her ~~his/her~~ accrued PTO and does not otherwise make up the time off within the same pay period, the partial day absence will be unpaid time off.

Directors, managers, and supervisors are accountable to ensure that attendance and timekeeping policies and procedures are adhered to, to monitor their employees' attendance on a daily basis, reasonably verify the accuracy of the timekeeping entries for non-exempt employees, and address attendance issues in a timely and consistent manner.

See ~~Human Resources Policy~~CalOptima Policy GA.8059: Attendance and Timekeeping

## Workweek and Workday

The workweek on which weekly overtime calculations will be based begins each Sunday at midnight (12:01 a.m.) and ends the following Sunday at midnight. The ~~work week~~workweek will differ for employees working an alternative schedule such as 9/80 (see section regarding Alternative Work Schedules).

## Payment and Wages

Normal paydays are every other Friday. Please consult CalOptima's pay schedule available through the Payroll Department.

Each paycheck will include base earnings for all reported hours performed through the end of the payroll period. The payroll period ends the Sunday prior to pay day at 12 a.m. An itemized statement of wages is available each payday online in Dayforce. If the payday (Friday) falls on a holiday, payroll checks will be available on Thursday.

## Payment on Resignation or Termination

According to California Labor Code Section 220 (b), as a public agency, CalOptima is not required to pay wages immediately upon termination. If an employee resigns or is terminated, his or her final paycheck will be available on CalOptima's next regularly scheduled payday. The employee's final paycheck will include payment for all wages due and not previously paid and for accrued but unused PTO/Flexible Holiday, minus authorized deductions.

## Overtime

**Hourly (Non-Exempt) Employees**
Periodically, a need for overtime arises, either before or after the regular workday or on weekends. As a public agency, we follow federal wage and hour laws. Overtime will be provided for all hours worked in excess of forty (40) hours in any one (1) ~~work week~~workweek at the rate of 1½ times the non-exempt employee's regular rate of pay. Overtime must be approved in advance by management.

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**Salaried (Exempt) Employees**
Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

## Meal and Rest Periods

CalOptima recognizes how important it is to have a break during the work day. As a result, CalOptima encourages employees who work for a period of more than five (5) hours to take an unpaid meal period of at least thirty (30) minutes. CalOptima also recommends a paid rest period of no more than fifteen (15) minutes to be taken approximately halfway through any work period of three and one-half (3.5) hours, or more. For example, employees should receive one (1) fifteen (15)-minute rest period in the first half of an eight (8)-hour shift, and one (1) fifteen (15)-minute rest period in the second half of an eight (8)-hour shift. Employees may not combine their breaks and lunch to alter their normal work hours.

## Lactation

Employees may take a reasonable amount of break time, subject to certain limitations, in order to express milk for the employee's child. The break shall run concurrently with rest breaks or lunch periods already provided to the employee but shall otherwise be unpaid.

## Holiday Pay

Employees are paid their regular straight-time wages for CalOptima paid holidays as set forth in the Holidays section under Benefits in this handbook.

## Make Up Time

CalOptima allows the use of makeup time when employees need time off to tend to personal obligations. For example, an employee might request makeup time in advance for the following situations:

- An employee needs to leave one (1) hour early for a doctor's appointment on Monday and asks to make up that time on Tuesday by working an hour later.
- An employee on a 9/80 workweek will receive eight (8) hours of holiday pay on a nine (9) hour day and he or she asks in advance to make up the additional hour rather than take it from his or her PTO accruals.

Make up time worked will not be paid at an overtime rate and the ~~work week~~ workweek in which the makeup time occurs cannot exceed forty (40) hours. Employees may take time off and then make up the time later in the same ~~work week~~ workweek or may work extra hours earlier in the ~~work week~~ workweek to make up for time that will be taken off later in the ~~work week~~ workweek.

Non-exempt employees should submit make up time requests in advance to their supervisor. Requests will be considered for approval based on the legitimate business needs of the department at the time the request is submitted. A separate written request is required for each occasion the employee requests make up time.

An employee's use of make-up time is completely voluntary. CalOptima does not encourage, discourage, or solicit the use of make-up time.

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# Supplemental Compensation

In certain instances, CalOptima offers supplemental compensation, in addition to an employee's regular base pay, to compensate for business needs. Supplemental compensation includes, but is not limited to, compensation for:

- **Overtime Pay:** Non-exempt employees will be paid overtime pay at a rate of one and one-half (1.5) times the employee's regular rate of pay for all hours worked in excess of forty (40) hours in any one (1) workweek. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.
- **Night Shift Pay:** A non-exempt employee who works an assigned night shift shall, in addition to his or her regular base pay, be paid a supplemental night shift pay for each hour actually worked on the assigned night shift.
- **Bilingual Pay:** A supplemental bilingual pay may be paid to qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages and bilingual usage for members is required or preferred in the job description.
- **Call Back Pay:** In certain departments, non-exempt employees are eligible for call back pay should they be asked to physically return to work within one (1) hour by their supervisor.
- **On Call Pay:** On occasion, employees may be asked to be on call. On call pay is compensation provided to employees who must remain accessible after hours and/or on the weekends via pager, or mobile phone, and be available to work via phone, fix problems or report to work, if necessary.
- **Active Certified Case Manager (CCM) Pay:** Supplemental pay may be paid to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties.
- **Sales Incentive Program:** Eligible employees in the Member Outreach & Education Department may be eligible to receive a sales incentive that corresponds to the number of eligible members the employee enrolls in the OneCare and OneCare Connect Programs each month.
- **Translation Pay:** The Cultural and Linguistic Services Program may compensate CalOptima exempt employees outside of their department for translation work.
- **Executive Incentive Program:** The Chief Executive Officer may recognize executive staff, including interim appointments, using incentive compensation as described in CalOptima Policy GA.8042: Supplemental Compensation. For executive staff who achieve superior performance, the executive incentive compensation is considered bonus pay pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as special compensation for classic Members.

See ~~Human Resources Policy~~CalOptima Policy GA.8042: Supplemental Compensation

# Severance Pay

The Chief Executive Officer (CEO), in his sole and complete discretion, may authorize severance pay upon an employee's separation from service when it is deemed appropriate due to special circumstances; e.g., separations due to changing needs of CalOptima, a reorganization of functions or staffing, lack of work, changes in the technology or methods used for a specific position, and/or resolution of a potential dispute.

See ~~Human Resources Policy~~CalOptima Policy GA.8047: Reduction in Force

# Merit Pay

The annual performance review period established by the Chief Executive Officer is typically April 1–March 31, with the annual salary review date occurring in July. In the event a performance review date is delayed for an employee and a positive performance review is given for the covered period that results in a recommended salary increase, CalOptima may make salary adjustments retroactive to the original performance review date with the

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approval of the Human Resources Department and subject to the guidelines set by the Human Resources Department.

## Unemployment Compensation

CalOptima contributes to the California Unemployment Insurance Fund ~~pays into Unemployment Compensation~~ on behalf of the employee. This insurance provides income in the event an employee loses his or her job through no fault of his or her own. Eligibility for Unemployment Insurance is determined solely by the Employment Development Department (EDD) of the State of California. Qualified employees should register at their nearest Employment Development Department in order to receive benefits. The amount of unemployment insurance payments varies according to income level.

## Short-Term Disability

CalOptima does not participate in the State of California Disability Insurance Plan. Instead, CalOptima operates under an approved private plan of disability insurance. This plan provides for loss of income resulting from non-work-related illness or injury, paying ~~sixty~~ seventy percent (7~~6~~0%) of regular income for up to a maximum of twelve (12) weeks for all benefit-eligible employees. There is a fourteen (14) calendar day waiting/elimination period on illness-related and accident-related disabilities. CalOptima provides this benefit free of charge to employees.

## Long-Term Disability

CalOptima provides a rich long-term disability program. Regular full-time and part-time employees are eligible to receive long-term disability coverage, following a ninety (90) calendar day waiting period, during which short-term disability is provided the first month following ninety (90) calendar days of employment. All benefit eligible employees are automatically enrolled into this benefit.

## Alternative Work Schedules (9/80)

CalOptima has established an alternative workweek schedule as another way for employees to manage work/life balance and provide CalOptima the opportunity to maintain productivity through different work schedules. Employees will be considered for alternative workweek scheduling on a case-by-case basis. The department director/manager is responsible for identifying if an alternative ~~work week~~ workweek is practical and effective for their department by evaluating both the productivity and quality impacts of the schedule to the department and the needs of the department to ensure service goals can be consistently achieved.

The 9/80 alternate work schedule consists of eight (8) business days of nine (9) work hours per day and one (1) business day of eight (8) work hours for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8)-hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each ~~work week~~ workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) workweek.

Not every position at CalOptima is eligible for alternative work scheduling. Full-time e~~E~~mployees who are interested should discuss this with their supervisor. Employees must receive approval from their supervisor and Human Resources to participate in the 9/80 work schedule. Employees not meeting job standards or expectations and/or who are on a performance improvement plan may not participate in the compressed work schedule until

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performance standards are met. Managers will review such exceptions with Human Resources before denying the option. Transitioning to the new ~~work week~~ workweek can result in either fewer, or more, than eighty (80) hours in a pay period. Human Resources will work with management to minimize incurring overtime during the transitional period.

Paid time off (PTO) accrual will remain the same for participating employees. When an employee takes a day off under the PTO policy, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9)-hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9)-hour workday, the employee has the option of using one (1) hour of accrued PTO or working one (1) hour of make-up time during the same ~~work week~~ workweek. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same ~~work week~~ workweek.

Employees are expected to continue to provide the same level of excellent service expected of them. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 work schedule based on business needs or performance issues. As a condition of participating in the 9/80 work schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager.

The 9/80 alternate work schedule is an optional program. CalOptima reserves the right to discontinue the entire program, or an individual employee's participation in the program at any time, for any reason, at management's discretion. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

See ~~Human Resources Policy~~CalOptima Policy GA.8020: 9/80 Work Schedule

## ~~Telecommuting~~Telework

CalOptima is committed to providing a work environment that assists employees to achieve a proper balance between their work, home and family obligations. In some cases, this balance can best be achieved by allowing employees to perform ~~some or all of~~ their work from their homes when they can do so without compromising their work quality, efficiency, or productivity. Telework is not a universal employee benefit, or entitlement, but an alternative method of meeting the work needs of the organization through a flexible work structure. Telework is a voluntary workplace arrangement in which an eligible employee works his or her entire work schedule away from the central worksite at a remote work location~~,~~.

An employee's participation in ~~Tele~~the Telework Program ~~commuting~~ must be pre-approved by an employee's supervisor, director, Environmental Health & Safety Manager, and Human Resources. A Telework~~commuting Agreement~~ Agreement, other mandatory pre-deployment documentation and a telework orientation must be completed before an employee may begin working from their residence. ~~telecommuting.~~

To participate in the telework program, an employee must meet eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from their home and their ability to meet performance expectations in a remote work environment. A teleworker must also maintain a suitable and secure designated workspace inside their residence that is clean, safe, and free from distractions. CalOptima's policies, rules and practices and the employee's conditions of employment are all applicable to a teleworker.

CalOptima retains the right, in its sole discretion, to designate positions that are appropriate for ~~telecommuting~~teleworking and approve employees for ~~telecommuting~~teleworking. ~~Telecommuting~~Teleworking does not change the conditions of employment or required compliance with all CalOptima policies and procedures. CalOptima reserves the right to change, or terminate, the ~~Telecommuting~~Telework Agreement at any time, with or without cause, or advance notice. An employee's ability to work under a ~~Telecommuting~~Telework Agreement rests in the sole discretion of CalOptima and requires that the employee be and remain in good

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standing. Any employee placed on a performance improvement plan or issued any other corrective action shall be removed from and is not eligible for ~~telecommuting~~teleworking. ~~Telecommuting~~Teleworking is a voluntary ~~n~~alternative work arrangement ~~privilege~~ and may not be appropriate for all employees and/or all positions. Any employee wishing to telework must first discuss this option with his or her supervisor and Human Resources.

When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a remote work location on an occasional basis. Occasional is defined as rare, infrequent, and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a remote work location routinely. This is not considered or counted as a telework position.

Employees who occasionally work from a remote work location must abide by the same requirements as employees who telework. An employee who occasionally works off-site must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department.

~~Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.~~

See ~~Human Resources Policy~~CalOptima Policy GA.8044: Telework Program

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17 # Leaves of Absence
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# Leaves of Absence Overview

CalOptima will grant a leave of absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures and all applicable laws. An employee's manager may approve up to five (5) business days of excused absences for an illness, or pre-planned surgery; however, absences of more than five (5) scheduled work days for illnesses, or pre-planned surgery must be submitted to and approved by HR for LOA consideration. Use of PTO time for pre-planned vacations does not require HR approval.

If the LOA is granted, the start date of the LOA will be the first day of the requested, substantiated, and approved LOA. Requests for a LOA must be made through the Human Resources Department. To be eligible, employees are required to submit all applicable forms, including, but not limited to, sufficient medical documentation, to the Human Resources Department in a timely manner, unless in special circumstances where timely submission may not be feasible.

Employees who satisfy the eligibility requirements set out in CalOptima's respective policies and applicable laws may be granted one (1) or more of the following types of LOAs. These leaves include:

a. Pregnancy Disability Leave
b. Family Medical Leave
c. California Family Rights Leave
d. Military Family Leave
e. Military Service Leave
f. Military Spouse Leave
g. Workers' Compensation Leave
h. Jury or Witness Duty Leave
i. Parental School Attendance
j. Voting Leave
k. Victims of Domestic Violence, Sexual Assault, or Stalking Leave
l. Victims of Crime Leave
m. Volunteer Civil Service Leave
n. Civil Air Patrol Leave
o. Bereavement Leave
p. Personal Leave

Employees taking any LOA must use their full balance of PTO before moving to unpaid leave, unless deemed otherwise by law (e.g., Pregnancy Disability Leave, etc.).

Employees may not engage in outside work for other employers while on an approved leave of absence from CalOptima, other than military service. ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence, defines further compensation requirements applying to employees taking LOA.

Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, or Automobile Allowance during his or her ~~his/her~~ LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA, but shall not be eligible if the LOA is unpaid. ~~Executive incentives will be prorated to account for the LOA time period, and executives must be on active status at the time the executive incentive is paid out in order to be eligible to receive the executive incentive.~~ Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

See CalOptima Policies; GA.8037: Leave of Absence, GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence, GA.8040: Family and Medical Leave Act (FMLA) and California

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Family Rights Act (CRFA) Leaves of Absence~~Family and Medical Leave Act and California Family Rights Act Leave~~, GA.8041: Workers' Compensation Leave of Absence

# Types of Leaves:

## Pregnancy Disability Leave

Pursuant to the California Fair Employment and Housing Act (FEHA), Pregnancy Disability Leave (PDL) is available to eligible employees who are temporarily disabled by pregnancy, childbirth, or a related medical condition. PDL is available for up to four (4) months, including intermittent periods.

An employee may request to use accumulated PTO during the PDL and is eligible for disability benefits. If PDL is foreseeable, and when practicable, a thirty (30) calendar day advance notice is required. Health benefits and other insurances will continue during the PDL period, and the employee is required to pay her portion of coverage at the active employee rate, either by the usual payroll deduction if the employee is still receiving a paycheck, or by making other payment arrangements with the CalOptima Human Resources Department.

See ~~Human Resources Policy~~CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence

## Family Medical Leave Act and California Family Rights Act Leave

State and federal family and medical leave laws provide up to twelve (12) workweeks of unpaid family/medical leave within a twelve (12)-month period. Full-time and part-time employees must meet the following conditions:

- The employee must have a total of at least twelve (12) months of service at CalOptima.
- The employee must have worked at least one thousand two hundred fifty (1,250) hours during the previous twelve (12)-month period before the need for leave.

An eligible employee may take continuous, intermittent or reduced schedule, when medically necessary,~~an~~ unpaid leave of absence under the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) for the following reasons:

- To care for the employee's newborn child, or placement of a child with an employee for adoption, or foster care.
- To care for the employee's spouse, ~~registered~~ domestic partner, child, ~~or~~ parent, grandparent, grandchild, or sibling who has a serious health condition.
- For the employee's own serious health condition that makes the employee unable to work at all, or unable to perform the functions of his or her job (While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.).
- To care for a spouse, child, or parent who is a covered military service member on active duty, or has been notified of an impending call, or order, to active duty.
- To care for a covered military service member with a qualifying serious injury or illness if the employee is the spouse, child, parent, or next of kin of the military service member. Under FMLA, an eligible employee may take up to twenty-six (26) weeks, during a single twelve (12)-month period, of unpaid leave to care for a covered service member with a qualifying serious injury, or illness.

An employee is required to use accumulated PTO during FMLA and/or CFRA LOA, unless deemed otherwise by law and may be eligible for disability benefits if the LOA is due to his or her own illness. If FMLA/CFRA is foreseeable, and when practicable, a thirty (30) calendar day advance notice is required. Health benefits and other insurances will continue during the FMLA/CFRA leave period and the employee is required to pay his or her

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portion of coverage at the active employee rate.

See ~~Human Resources Policy~~CalOptima Policies;~~y~~ GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence

## Coordination of PDL with FMLA and/or CFRA

If an employee takes PDL and is eligible for a LOA under FMLA and/or CFRA, CalOptima will continue to make payments towards group health insurance coverage during the period of the PDL, FMLA and/or CFRA, subject to the employee's timely payment of his or her portion of coverage at the active employee rate. For any leave taken under PDL, FMLA runs concurrently with PDL, and may run concurrently with CFRA if less than twelve (12) weeks of PDL are taken.

If an employee is ineligible under FMLA and CFRA for a LOA, CalOptima will continue to pay the employer's portion of payments to group health insurance coverage during the period of the PDL, subject to the employee's timely payment of his or her portion of coverage at the active employee rate. In some instances, CalOptima may recover premiums it paid to maintain health coverage for an employee if the employee fails to return to work following PDL.

If an employee exhausts her PDL and any other protected leave, and the employee is granted a Personal LOA, CalOptima will not pay for group health insurance premiums during any remaining portion of a Personal LOA. The employee is fully responsible for timely electing COBRA health coverage and paying for the full cost of health insurance premiums during the remaining portion of the Personal LOA. Failure to timely make the COBRA election and/or failure to pay premiums in a timely manner will result in immediate termination of coverage through the remainder of the Personal LOA.

See ~~Human Resources Policy~~CalOptima Policies;~~y~~ GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence

## Military Service Leave

CalOptima employees who are members of "uniformed services" (e.g., Army, Navy, Air Force, Marine Corps, Coast Guard, and the reserves of each of those branches: Army National Guard, Air National Guard, or similar branches) will be granted, upon request, a cumulative of five years of leave of absence (with certain exceptions) without pay for both inactive and active duty (e.g., military training, drills, encampments, cruises, special exercises, or similar activities). All regular full-time and part-time employees are eligible for Military Service Leave.

In certain circumstances employees on a Military Service Leave may be entitled to up to thirty (30) calendar days' salary and benefits continuation in any one (1) fiscal year.

Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty, or active training duty, with the U.S. Armed Forces, or National Guard, as a result of the National Emergency arising from the War on Terror, may receive supplemental compensation and continuation of benefits during the Military Service Leave.

Employees will be required to complete a Leave of Absence Request form and provide a copy of all military orders to the Human Resources Department.

An employee who returns from a Military Service Leave will be reinstated to the same position, or a position of like seniority, status, and pay in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and Section 395.1 of the California Military and Veteran's Code.

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See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Military Spouse Leave

In addition, employees who are regularly scheduled to work an average of twenty (20), or more, hours per week and who are spouses of qualified military service members, are eligible to take up to ten (10) scheduled work days of unpaid leave when their spouses are on leave from active duty in the U.S. armed forces, reserves, or National Guard. Employees may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid. Employees must give a minimum of two (2) business days' notice of their need for leave and provide appropriate written documentation to the Human Resources Department.

See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Workers' Compensation Leave

In accordance with state law, CalOptima provides Worker's Compensation insurance coverage for employees in case of a work-related injury or illness. Employees are required to report all on-the-job injuries to their supervisor and the Human Resources (HR) Department immediately, regardless of how minor the injury may be. Employees who sustain a work-related injury or illness may be granted a leave of absence as required by law. CalOptima may grant a Leave of Absence (LOA) consistent with CalOptima's various leave policies to any employee who is unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act.

While employees are on a leave of absence, they should stay in contact with CalOptima's Human Resources Department and their supervisors regarding their expected return to work. CalOptima may engage in an interactive process (where applicable) with the employee to determine if there are any reasonable accommodations available that may be effective in allowing the employee to return to work or whether extended time off will be a reasonable accommodation or create an undue hardship on CalOptima. Subject to any limitations permitted by law, including, but not limited to, business necessity or undue hardship, time off for work-related injury or illness may be extended to the employee for the duration of the injury or illness, until the employee has recovered sufficiently to perform the duties of his or her job or a modified light duty position if one is offered by CalOptima, or the employee's condition is declared permanent and stationary and he or ~~/she~~she is unable to perform the essential functions of his or her job, with or without reasonable accommodation.

See ~~Human Resources Policy~~CalOptima Policy GA.8041: Workers' Compensation Leave of Absence

## Jury or Witness Duty Leave

CalOptima will grant a LOA with regular pay for those hours that coincide with the employee's regularly-scheduled working hours for the purpose of jury service, appearance as a witness in court (other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee.) Employees are required to provide reasonable advance notice of any need for such leave.

On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members. Employees seeking an

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official Jury Duty Leave should submit to their immediate supervisor a Leave of Absence Request Form ~~memo for absence~~ accompanied by a copy of the official order not less than ten (10) calendar days prior to the beginning of the date of the leave. The employee must submit to the Payroll Department the payment received for the jury service, excluding payments for mileage.

See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Parental School Attendance

Pursuant to Labor Code Section 230.8, employees can take time off up to eight (8) hours in one (1) month, or forty (40) hours each year to participate in school activities of their children, subject to limitations under applicable laws. Pursuant to Labor Code Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code Section 48900.1 (suspension of pupil), subject to conditions. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

## Bereavement Leave

With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step, or foster child; biological, adopted, step, or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documents for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO or unpaid time off. If the employee plans to take additional ~~unpaid~~ time off exceeding five (5) scheduled work days, the ~~An~~ employee must submit an LOA request form to HR and request a Personal LOA pursuant to ~~Human Resources Policy~~CalOptima Policy GA.8038: Personal Leave of Absence. ~~if the employee plans to take additional unpaid time off exceeding five (5) scheduled work days.~~

## Time Off for Voting

CalOptima encourages employees to fulfill their civic responsibilities by voting. Employees who are unable to vote before or after work should request time off to vote from their supervisor at least two (2) working days prior to election day so that the necessary time off can be scheduled at the beginning or end of the work day, whichever provides the least disruption to the normal work schedule.

See California Elections Code, Section 14000

## Victims of ~~Domestic Violence, Sexual Assault or Stalking Leave~~Crime or Abuse

Subject to the requirements under Labor Code ~~S~~sections 230 and 230.1, an employee who is a victim of a crime or abuse~~domestic violence, sexual assault, or stalking~~ may, with reasonable advance notice, unless the advance notice is not feasible, request an LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of a crime. Employees may elect to use accrued PTO, if available, when an LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a twelve (12)-month period. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid.

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See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Victims of Crime Leave

An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off to attend judicial proceedings related to that crime, subject to the procedural conditions imposed pursuant to Labor Code Section 230.2.

The absence from work must be in order to attend judicial proceedings related to a crime. To the extent feasible, before an employee is absent from work for such a reason, the employee much provides documentation of the scheduled proceeding. Such notice is typically given to the victim of the crime by a court, or government agency, setting the hearing, an attorney related to the case, or victim/witness office. Any absence from work to attend judicial proceedings will be unpaid unless employee chooses to use PTO.

See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Volunteer Civil Service Leave

A Civil Service LOA may be granted for employees who are required to perform emergency duty (reserve peace officers, volunteer firefighter, and emergency rescue personnel). There are no limitations to the amount of time an employee can use for volunteer civil service leave.

An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA not to exceed an aggregate of fourteen (14) scheduled work days per calendar year, for the purpose of fire, law enforcement, or emergency rescue training.

Any Volunteer Civil Service Leave can be taken unpaid unless employee chooses to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the required leave period and the time covered by PTO will still count as part of this leave.

Certification from emergency personnel office, or civil air authority, will be required to verify the employee's eligibility for leave requested.

See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Civil Air Patrol Leave

Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled work days per calendar year (three (3) days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty.

See ~~Human Resources Policy~~CalOptima Policy GA.8037: Leave of Absence

## Extended Disability Leave

Reasonable accommodations for a leave of absence may be granted for a recognized disability, including pregnancy disability and other serious medical conditions that prevent the employee from working, unless such extended leave causes CalOptima undue hardship and/or is indefinite in duration. Human Resources will engage

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in the “interactive process” with the employee and his or her manager to help determine whether a reasonable accommodation is available in order to grant such leave request.

Employees are required to use PTO during the leave of absence. Group health insurance plans (health, dental, and vision) will generally be made available via COBRA after all PTO and protected LOAs have been exhausted.

## Personal Leave

All full-time and part-time employees are eligible to request a Personal Leave of Absence.

A Personal Leave of Absence, without pay, may be granted, in CalOptima's sole discretion, for a reasonable period of time of up to a total of ninety (90) calendar days per twelve (12)-month period. Personal LOAs are entirely dependent on CalOptima’s discretion and are only approved when it is determined that granting the LOA will not unduly interfere with CalOptima's operations.

Any accumulated PTO must be used during Personal LOA. Once the employee’s PTO has been exhausted, all remaining time off during the approved Personal LOA will be unpaid. The use of such PTO will not adjust the start date of the leave; i.e., time covered by PTO will still count as part of the Personal Leave.

CalOptima does not guarantee that an employee’s position will remain vacant while the employee is on an approved Personal LOA. CalOptima may fill the employee’s position for business reasons.

If an employee's position is filled while he or she is off on an approved Personal LOA, the employee may, at the conclusion of his or her scheduled leave, apply for any open position for which he or she is qualified at CalOptima. However, if no such position is available, the employee's employment will be terminated.
If the employee fails to return to work at the agreed date, the employee will be treated as having voluntarily resigned his or her employment.

See ~~Human Resources Policy~~CalOptima Policy GA.8038: Personal Leave of Absence

## Kin Care

In a calendar year, e~~E~~mployees may use up to half of their annual accrued and available PTO for preventative care or care of an existing health condition for the employee or a family member as permitted under Labor Code, Sections 233 (generally known as “Kin Care,” but also referred to as “Protected Sick Leave”) and 246.5(a). Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code Section 230.8 and 230.7.

For purposes of PTO use, a “child” is defined as a biological, foster, or adopted child; stepchild; or a legal ward. A “child” also may be someone for whom an employee has accepted the duties and responsibilities of raising, even if he or she is not their legal child.

A “parent” is an employee’s biological, foster, or adoptive parent; stepparent; or legal guardian.

A “family member” includes a grandparent, grandchild, and sibling.

A “spouse” is an employee’s legal spouse according to the laws of California, which do not recognize “common law” spouses (a union that has not been certified by a civil or religious ceremony). All conditions and restrictions placed on an employee’s use of PTO apply also to PTO used for care of a child, parent, or spouse.

A “registered domestic partner” is another adult with whom an employee has chosen to share his or her life in an intimate and committed relationship of mutual caring, and with whom they have filed a Declaration of Domestic

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1 Partnership with the Secretary of State of California (or another state that allows for such).
2
3 A “registered domestic partner’s child” is the biological, foster, or adopted child, stepchild, or legal ward of an
4 employee’s domestic partner. A “domestic partner’s child” also may be someone for whom an employee’s
5 domestic partner has accepted the duties and responsibilities of raising, even if he or she is not the domestic
6 partner’s legal child.
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17 **Safety and Security**

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# Safety

CalOptima is committed to providing and maintaining a healthy and safe work environment for all employees. CalOptima believes that the establishment and maintenance of a safe work environment is the shared responsibility of CalOptima and employees at all levels of the organization. CalOptima will attempt to establish a safe environment in compliance with federal, state, and local safety regulations.

Accordingly, CalOptima has instituted an Injury and Illness Prevention Program designed to protect the health and safety of all personnel. A complete copy of the Injury and Illness Prevention Program is kept in the Facilities Department and is available for employees' review.

Every employee is required to know and comply with CalOptima's general safety rules and to follow safe and healthy work practices at all times. Employees may be subject to corrective action, up to and including termination, for engaging in any unsafe or unhealthy work practice or for violation of established safety rules. Each employee is also required to report to his or her supervisor any potential health or safety hazards and all injuries or accidents.

First aid supplies are located in each lunch/copy room. Please report any work-related injuries, or illnesses, immediately to the Environmental Health and Safety Manager and/or Human Resources Department. If an employee witnesses or discovers an accident in which a CalOptima visitor or employee is injured, they are expected to assist the visitor or employee as much as possible, and if the situation is an emergency, to call 911. If the situation is not an emergency, employees should contact the Environmental Health and Safety Manager and/or Human Resources Department for further direction.

See ~~Human Resources Policy~~CalOptima Policy GA.8016: Unusual Occurrence

# Security

The security of employees, employee property, and CalOptima property is of vital importance. All employees share responsibility to ensure that proper security is maintained. Any breach of security should be reported promptly to the CalOptima security guard, manager or director of Facilities, and the Human Resources Department. Employees may call upon the CalOptima security guard for assistance by dialing zero (0) and having the receptionist page him/her. For immediate emergencies, dial 911.

The building security guard is stationed in the main lobby of the building. The building security guard hours are twenty-four (24) hours daily, Monday through Friday, and all Friday night until 6 a.m. Saturday morning. If an employee is working late and requires an escort to his or her vehicle, the employee may call the building guard, number located on the InfoNet. If an employee experiences a problem while working on the weekend, or after regular working hours, he or she should call the building after hours emergency number located on the InfoNet.

# Security Cameras

CalOptima takes the safety and security of its employees, members, and CalOptima guests very seriously. Proper video surveillance, where deemed appropriate and necessary, is one of the most effective means of helping to keep CalOptima facilities and properties operating in a safe and secure manner. Therefore, please be aware CalOptima has and monitors video surveillance cameras in common areas throughout its buildings and surrounding property for safety and security reasons. The use of video surveillance is for the purpose of controlling theft, ensuring the safety of CalOptima employees and members, and facilitating the identification of individuals who behave in a disruptive manner, cause damage to CalOptima property, or are otherwise in contravention of CalOptima's policies, procedures, and Code of Conduct.

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# Workplace Violence

CalOptima has a strong commitment to its employees and its members to provide a safe, healthy, and secure work environment. CalOptima has zero tolerance for acts of violence, threats, intimidation, or harassment, whether occurring on CalOptima property, occurring off CalOptima property but while conducting CalOptima business, or occurring off or on CalOptima property but directed towards another or other CalOptima employees. All such acts and threats, even those made in apparent jest, will be taken seriously, and will lead to corrective action, up to and including termination.

It is every employee's responsibility to assist in establishing and maintaining a violence-free and safe work environment. Therefore, employees are expected and encouraged to report any incident which may be threatening to them or their co-workers or any event which they reasonably believe is suspicious activity, threatening, intimidating, or violent. Employees may report an incident to any supervisor, or manager.

A threat includes, but is not limited to, 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, or destroy, property. This includes threats made in jest or as a joke, but which others could perceive as serious.

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. 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.

In emergency situations, employees may report workplace violence to supervisory, or managerial, level employees other than their own supervisors.

See CalOptima Policy GA.8053: Workplace Violence

# Ergonomics

CalOptima is subject to Cal/OSHA ergonomics standards for minimizing workplace repetitive motion injuries. CalOptima will make necessary adjustments to reduce exposure to ergonomic hazards through modifications to equipment and processes and employee training. CalOptima encourages safe and proper work procedures and requires all employees to follow safety instructions and guidelines.

CalOptima believes that reduction of ergonomic risk is instrumental in maintaining an environment of personal safety and well-being and is essential to our business. We ~~intend to~~ provide appropriate resources to create a risk-free environment. For more information, contact the Facilities Department.

# Inspections, Searches, and Monitoring of CalOptima Premises

CalOptima believes that it is important to the efficient and safe conduct of its business to assure access at all times to any property, equipment, records, documents, and/or files, etc. on its premises. CalOptima also believes that maintaining a workplace that is free of drugs, alcohol, firearms, explosives, and other harmful and improper materials is vital to the health and safety of its employees and to the success of the organization. CalOptima also intends to protect against the unauthorized removal of its property from the premises. Accordingly, CalOptima reserves the right to access, inspect, and search CalOptima property and premises at any time~~according to this policy~~.

Prohibited materials, including weapons, explosives, alcohol, and non-prescribed drugs or medications, may not be placed or stored in employees' work spaces or desks. If such prohibited items are found, they will be

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confiscated by CalOptima and delivered to the proper authorities. In addition, CalOptima reserves the right to inspect personal belongings including, but not limited to, any package, container, bag, briefcase, etc. carried in or out of CalOptima by any employee, volunteer, or visitor when deemed appropriate by management and/or CalOptima's security guards. Employees who fail to cooperate in any inspection will be subject to corrective action, up to and including termination.

CalOptima is not responsible for any personal belongings or items placed, or stored, in a work space or desk that is lost, damaged, destroyed, or stolen. Employees have an obligation to cooperate fully with all inspections, investigations, and searches conducted in accordance with this section; failure to do so may result in corrective action, up to and including termination.

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18 # Termination
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# Employment Verification

All requests for employment verification must be directed to the Human Resources Department. No other manager, supervisor, or employee is authorized to release employee information for current, or former, employees. By policy, CalOptima discloses only the dates of employment and the title of the last position held of former employees. If an employee authorizes the disclosure in writing, CalOptima will also inform prospective employers, mortgage companies, etc. of the amount of salary, or wage the employee last earned.

Employees may also participate in The Work Number® service from Equifax to provide automated income and employment verifications. Information about the service can be found on the InfoNet.

# Exit Interviews

At time of separation, employees will be scheduled for an exit interview with the Human Resources Department. This interview allows employees to communicate their views on their work with CalOptima, as well as provide input regarding the requirements, operations, and training needs of their former position. It also provides employees an opportunity to discuss issues concerning benefits and insurance. At the time of the interview, employees must return all CalOptima-furnished property, e.g., uniforms, tools, equipment, I.D. cards, keys (electronic and regular), laptops, cell phones, and CalOptima-related documents. Arrangements for clearing any outstanding debts with CalOptima and for receiving final pay will also be made at this time.

# Termination

We hope employees will enjoy a long and mutually rewarding employment relationship with CalOptima. Sometimes, however, an employee may find it desirable, or necessary, to resign and take employment elsewhere, or CalOptima may need to discharge an employee. In either case, it is important that employees who resign or are terminated are treated with mutual respect to achieve a professional, orderly transition.

An employee is considered to have voluntarily terminated his or her employment with CalOptima when the employee:

- Resigns from CalOptima.
- Fails to return from vacation or from an approved leave of absence at the scheduled date and time.
- Fails to report to work without notice or authorization for three (3) consecutive days.

Employees who elect to resign are asked to provide CalOptima with at least two (2) weeks' notice prior to their final day of work.

From time-to-time, CalOptima may reduce the size of the work force by terminating employees for business, operational, or economic reasons (such as lack of work, restructuring the workforce, reorganizing a department, or job elimination). Should CalOptima consider such terminations necessary, CalOptima will attempt to provide all affected employees with advance notice, when practical. Employees affected by such reductions in force are considered to have been laid-off.

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# Closing

As a CalOptima employee you are encouraged to exemplify the CalOptima mission of providing members with access to quality health care services delivered in a cost-effective and compassionate manner.

More information about CalOptima's policies, standards and practices may be found by consulting the individual policiesy referenced herein found on the InfoNet at Other Resources and Services, Policies and Procedures or by contacting Human Resources at hr@caloptima.org. Employees are responsible for reviewing new and updated policies upon notice of changes.

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Confirmation of Receipt

I have received my copy of CalOptima's Employee Handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained in the handbook.

I understand that except for employment at-will status, any and all policies or practices can be changed at any time by CalOptima, and it is my own personal responsibility to stay up-to-date with, be familiar with, and abide by any and all changes ins policies or practices. CalOptima reserves the right to change my hours, wages, benefits and/or working conditions at any time. I understand and agree that other than the Board of Directors and CEO of CalOptima, no manager, supervisor or representative of CalOptima has authority to enter into any agreement, express or implied, for employment for any specific period of time, or to make any agreement for employment other than at-will. I understand that if there is a conflict between a relevant law and this handbook, the law will supersede the handbook.

I understand and agree that nothing in the Employee Handbook creates or is intended to create a promise or representation of continued employment and that employment at CalOptima is employment at-will; employment may be terminated at the will of either CalOptima or me. My signature certifies that I understand that the foregoing agreement on my at-will status is the sole and entire agreement between CalOptima and me concerning the duration of my employment and the circumstances under which my employment may be terminated. It supersedes all prior agreements, understandings and representations concerning my employment with CalOptima.

Employee's Name (Printed): ____________________

Department: ____________________

Employee's Signature: ____________________ Date: ____________

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20 # Employee Handbook

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12 # Welcome Letter

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For 20210506 BOD Review Only

Thank you for choosing CalOptima as your employer. The dedication of our employees is critical to CalOptima's ability to fulfill its mission and deliver access to quality, compassionate care to all members. Although we have evolved into a multi-faceted organization, we are grateful that our employees remain fully committed to ensuring that all programs, initiatives, and services are centered on meeting the health care needs of our members.

We at CalOptima understand that excellence in service to our members could not happen without our most valued resource, our dedicated and caring employees. Our diverse and mission-driven staff works tirelessly to meet our members' health care needs. I am exceptionally proud of our employees and am fully committed to maintaining the employee-focused culture in which our employees thrive.

With the support of CalOptima's Board of Directors and the Member and Provider Advisory Committees, our strong network of physicians and hospitals, and the dedication and drive of our employees, CalOptima looks forward to fully engaging in new opportunities that will improve the delivery of health care services to our members and the Orange County community.

On behalf of the administrative staff and the Board of Directors, welcome to CalOptima.

Sincerely,

Richard Sanchez, Chief Executive Officer

Andrew Do, Chairman, CalOptima Board of Directors

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# Welcome to CalOptima

Welcome to CalOptima, a public agency and health plan that serves Orange County members of Medi-Cal, OneCare (Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), and PACE (Program of All-Inclusive Care for the Elderly). We believe you will find CalOptima an exciting organization with an important mission that is fulfilled through the collective efforts of our employees. You are joining our staff of dedicated and talented professionals, and we are confident that your skills and experience will assist us in achieving our mission.

# Our Personal Challenge

CalOptima's success is a direct result of the important contributions our employees make every day. We challenge all employees to keep our members front and center in all that they do. Our commitment to our members goes beyond the Customer Service Department, and we recognize that we would be unable to implement our important mission without our providers. We also recognize we need to serve all of our customers which include members, health networks, pharmacies, ancillary providers, physicians and their staff, and CalOptima employees.

But more than just meeting our members' needs, we strive to anticipate what they need and recommend it before they ask. We strive to be good stewards of public funds and honor our accountability to the community by working together to keep administrative costs as low as possible while improving the quality of care for our members and the effectiveness of our providers.

To do this, we must continually evaluate and reinvent the way we do business. Identifying opportunities for improving efficiency and effectiveness is the responsibility of all CalOptima team members. With your help, we will continue to build a team-oriented environment where innovation and flexibility are the standards for achieving our mission.

# Mission Statement

CalOptima's mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

# About This Handbook

This handbook is provided for your use as a reference and as a summary of CalOptima's mission, history, employment practices, key employee policies, procedures, and benefits. Because CalOptima is a dynamic and changing organization, at times it may be necessary to change or improve the policies and practices presented in this handbook. As CalOptima deems appropriate in its sole and absolute discretion, CalOptima reserves the right to amend, supplement or rescind this handbook, or any portion(s) herein, other than CalOptima's employment-at-will provisions. This handbook is not a contract, either express or implied, of continued employment.

Employees are encouraged and expected to read and familiarize themselves with the contents of this handbook and should consult with their manager and/or Human Resources to obtain clarification or detailed information regarding any policy, procedure, or practice outlined in this handbook.

CalOptima is constantly striving to improve its policies, procedures, and services. We encourage employees to bring suggestions for improvements to their managers. By working together, we hope to share with all of our employees a sincere pride in our workplace and the services we are all here to provide.

This handbook supersedes all previously issued handbooks but does not supersede applicable federal, state, or local laws. Your manager or the Human Resources Department will be happy to answer any questions you may have.

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# Right to Revise

This employee handbook summarizes some of the employment policies and practices of CalOptima in effect at the time of publication. A full list of policies may be found on the CalOptima InfoNet. All previously issued handbooks and any inconsistent policy statements or memoranda in effect prior to the effective date of publication are hereby superseded to the extent it conflicts with this handbook.

CalOptima reserves the right to revise, modify, delete, or add to any and/or all policies, procedures, work rules, or benefits stated in this handbook or in any other document, except for the policy of at-will employment.

Any written changes to this handbook will be made available to all employees via CalOptima's InfoNet and/or via email communication so that employees will be aware of the new policies or procedures. No oral statements, or representations, can in any way alter the provisions of this handbook.

Nothing in this employee handbook or in any other personnel document, including benefit plan descriptions, creates or is intended to create, a promise or representation of continued employment, for any employee.

# The History of CalOptima

CalOptima was established as part of a community effort to improve access to health care services for Orange County's low-income residents. The Orange County Board of Supervisors created CalOptima in 1993 as a county organized health system (COHS), which is a public agency. CalOptima is one of six COHS authorized by federal and state law to administer Medi-Cal benefits in California. This health care model allows local decision-making and ensures the plan is community-driven. CalOptima's mission is to provide access to quality health care services delivered in a cost-effective and compassionate manner.

In October 1995, CalOptima launched our Medi-Cal program with 180,000 members. That program remains our flagship today, with 2018 membership approaching 800,000 members. In the years since Medi-Cal was established, CalOptima went on to launch other programs for important segments of Orange County's low-income population.

In 1998, CalOptima launched the Healthy Families Program (HFP) to provide health care coverage for children up to the age of nineteen (19) who met eligibility requirements based on family income. In 2013, HFP members were transitioned into CalOptima Medi-Cal at the direction of state legislation.

In 2005, CalOptima launched OneCare, our Medicare Advantage Special Needs Plan (HMO SNP). OneCare was created through a contract with the Centers for Medicare & Medicaid Services (CMS) to offer enhanced care coordination and streamlined health care delivery by combining the Medicare and Medi-Cal benefits into a single plan.

In 2013, CalOptima launched a Program of All-Inclusive Care for the Elderly (PACE), which is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elderly participants to help them continue living independently in the community.

In 2015, CalOptima launched OneCare Connect, a new health plan designed to simplify and improve health care for seniors and people with disabilities who have Medicare and Medi-Cal coverage. The plan combines Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support.

CalOptima has maintained an outstanding record of quality for our members. Since 2014, we have been leading California in Medi-Cal quality, according to the National Committee for Quality Assurance. It is an honor we strive to uphold as we aim to fulfill our mission, but we cannot accomplish this alone. As a community health plan, we rely on private health care networks, including nearly 1,600 primary care providers and more than 7000 specialists to deliver the services our members need. Further, CalOptima is proud to administer our programs in a cost-effective manner and is consistently recognized as having one of the lowest administrative cost ratios among all Medi-Cal managed care plans in California.

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## At-Will Employment Status

CalOptima employees are at-will employees with no guarantee of employment for any specified term. CalOptima recognizes that relationships are not always mutually satisfactory. To protect both parties' rights, the employment relationship at CalOptima is terminable at-will, at the option of the employee, or CalOptima. An employee, or CalOptima, may terminate employment at any time, with or without cause, and with or without notice. As a professional courtesy, employees are encouraged to provide no less than two weeks' notice of termination to ensure adequate time to transition job responsibilities.

CalOptima reserves the right to change the conditions of an employee's employment including, but not limited to, compensation, duties, assignments, responsibilities, and location at any time, with or without cause. There are no written, oral, or implied promises of permanent, or continuing employment. This status supersedes any such agreements to the extent that any may exist.

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17 # Required Policies
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# Equal Employment Opportunity

CalOptima is an equal employment opportunity employer and makes all employment decisions on the basis of merit. CalOptima wants to have qualified employees in every job position. CalOptima prohibits unlawful discrimination against any employee, or applicant for employment, or those applying for or engaged in a paid or unpaid internship or training program leading to employment with CalOptima based on race, religion, religious creed, color, national origin, ancestry, mental or physical disability, medical condition, genetic information, marital status, sex, sex stereotype, gender, gender identity, gender expression, gender transition status, pregnancy, age, sexual orientation, military status, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state, or local laws. CalOptima also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics or is associated with a person who has, or is perceived as having, any of those characteristics.

Equal employment opportunity will be extended to all persons in all aspects of the employer-employee relationship, including recruitment or recruitment advertising, hiring, training, promotion, rates of pay or other forms of compensation, benefits, transfer, discipline, layoff or termination, career development opportunities, and social and recreational programs.

CalOptima prohibits retaliation for bringing a complaint of discrimination or harassment against any person employed, seeking employment, providing contract services, or applying for or engaged in a paid or unpaid internship, volunteer capacity, or training program leading to employment with CalOptima. CalOptima also prohibits retaliation to a person that assists someone with a complaint of discrimination or harassment. Retaliation may include threats, intimidation, and/or adverse actions related to employment. Employees engaging in any actions which are retaliatory against another employee as described herein will be subjected to corrective action, up to and including termination of employment.

It is the responsibility of every manager and employee to conscientiously adhere to this policy.

See CalOptima Policy GA.8025: Equal Employment Opportunity

# Unlawful Harassment and Discrimination

CalOptima is committed to providing a work environment that is free of unlawful harassment, discrimination, and retaliation.  CalOptima prohibits unlawful harassment and/or discrimination against any employee, or applicant for employment, based on race, sex, sex stereotype, gender, gender identity, gender expression, transitioning status, age, color, national origin, immigration status, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status, medical condition, genetic information or any other protected characteristic is a violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as corrective action, up to and including termination of employment.

Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that is based on a protected characteristic and which creates an intimidating, offensive, or hostile work environment (must be severe or pervasive) or that interferes with work performance.

CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee who believes he or she is being, or has been, harassed or discriminated against based on a protected characteristic in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager or, if he or she prefers, to the Human Resources Department. Supervisors and managers must report incidents or claims of harassment immediately to the Human Resources Department. A Human Resources representative will investigate any and all complaints of unlawful harassment or discrimination and take appropriate preventive and/or corrective action when it is warranted. Reported complaints of unlawful harassment based on protected characteristic will be investigated fairly, thoroughly, promptly, and in a confidential manner to

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1 the extent possible, involving only the parties who have a need to know.
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3 CalOptima is committed to educating all staff and leaders on harassment prevention upon hire and every two (2)
4 years thereafter as required by law.
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6 CalOptima will not tolerate retaliation against an employee for reporting harassment and/or discrimination, for
7 cooperating in an investigation, for making compliance complaints or for making any other complaint to the
8 Human Resources Department. Employees engaging in any actions which are retaliatory against another
9 employee will be subjected to corrective action, up to and including termination of employment.
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11 It is the responsibility of every manager and employee to conscientiously adhere to this policy.
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13 See CalOptima Policy GA.8027: Unlawful Harassment
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18 # Recruitment and Hiring
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# Job Posting

CalOptima supports the development and advancement of employees from within the organization, and that belief is supported by CalOptima's job posting process. Employees are responsible for taking ownership of their own career and checking new and current job postings for growth and advancement opportunities. CalOptima encourages employees to apply for promotions, or transfers, to open positions for which they meet the qualifications and minimum requirements.

Upon completion of the Request to Fill (RTF) process, positions will normally be posted internally and/or externally. Open positions must be posted internally for five (5) full business days before an offer can be made. On rare occasions, there may be situations where a position is not posted or is not posted for the full five (5) business days due to a sensitive business need. The exceptions from posting must be approved by the Chief Executive Officer.

Employees are not eligible to apply for posted jobs until they have completed at least six (6) months' service in their current position. Exceptions to the six (6) month waiting period may be made with approval from the Chief Executive Officer when in the best interest of CalOptima. Employees must possess the necessary education, skills, and experience for the job position, complete an internal job application (including an updated résumé) and be in good standing to apply for open positions. As a courtesy, it is recommended that employees notify their managers upon applying.

See CalOptima Policy GA.8019: Promotions and Transfers

# Background Check

CalOptima believes that hiring qualified individuals to fill positions contributes to our overall strategic success. Background checks serve as an important part of the selection process. CalOptima employees have access to confidential, private, and protected health information. Through comprehensive background checks, CalOptima can obtain additional applicant-related information that helps determine the applicant's overall employability and ensures the protection of the people, property, and information of the organization.

CalOptima uses a third-party agency to conduct the background checks. The type of information that can be collected by this agency includes, but is not limited to, information pertaining to an individual's past employment, criminal background, education, character, credit record (where applicable), Department of Motor Vehicles (DMV) record, and reputation. Background checks are held confidentially in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

CalOptima conducts background checks on job applicants prior to commencement of employment. For promotions or transfer of employees to certain positions, or for unique circumstances, a post-employment background check may also be required. Falsification of information on the employment application or providing false information or incomplete information for the purpose of hiring or maintaining employment may result in corrective action, up to and including termination of employment. Employees shall timely notify HR of any licenses or certifications that they hold in California or other states that have been revoked, suspended, or restricted due to misconduct or disciplinary action. Employees shall also timely notify HR of any post-employment criminal convictions.

CalOptima also conducts exclusion monitoring through the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM) Website, and the Medi-Cal Suspended and Ineligible (S&I) Website. Any applicant found on the LEIE, SAM Website and/or Medi-Cal S&I Website and verified according to the Human Resources procedures cannot be hired with CalOptima. Similarly, any existing CalOptima employee found on the LEIE, SAM Website, and/or Medi-Cal S&I Website and verified according to the Human Resources procedures cannot be hired by or continue employment with CalOptima. Employees shall notify the Human Resources Department upon hire, or

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immediately any time thereafter, if the employee knows or has reason to know that the employee is excluded from a federally funded health care program and/or may be listed on the LEIE, SAM and/or Medi-Cal S&I Websites.

See CalOptima Policy GA.8030: Background Check

# Proof of Right to Work

In accordance with federal law, all new hires will need to produce original documentation establishing their identity and authorization to be legally employed in the United States. In addition, each new hire is required to complete an INS Form I-9 swearing that they are legally employable in the United States. This verification must be completed as soon as possible after an offer of employment is made and in no event more than three (3) business days after an individual is hired. All offers of employment and continued employment for positions in the United States are conditioned on furnishing satisfactory evidence of identity and legal authority to work in the United States. Employees are responsible for timely providing updated evidence of continued legal authority to work post-employment prior to or upon the expiration of any previously submitted documentation. Employees who fail to timely furnish satisfactory evidence of continued legal authority to work post-employment prior to or upon the expiration date of previously submitted documentation may be terminated.

# Job Duties

In order to run a cost-effective program at CalOptima, it is important that employees are flexible and do what needs to be done to best serve the needs of our members and customers. During the employee's initial orientation and during the initial performance review, management will explain job responsibilities and the performance standards expected of their employees. A general description of the essential job functions is contained in each position's job description. Be aware that job responsibilities may evolve and/or change at any time during the employment relationship. From time to time, employees may be asked to work on special projects, and/or to assist with other work necessary or important to the operation of their department or CalOptima. Cooperation and assistance in performing such additional work is expected. Employees may be exposed to disagreeable conditions typical of working with individuals in distress, as well as encounter normal stress and pressure associated with a fast-paced environment, including various deadlines and interactions with regulators and/or member of the public. Work volume may be consistent or vary at different times of the year.

CalOptima reserves the right, at any time, with or without notice, to alter or change job responsibilities, reassign or transfer job positions, or assign additional job responsibilities.

# Employment Classifications

CalOptima uses the following specific classifications to describe the responsibilities and benefits of employment:

**Full-Time:** Employees who are regularly scheduled to work sixty (60) to eighty (80) hours a pay period and are eligible for all employer-provided health care and retirement benefits.

**Part-Time:** Employees who are regularly scheduled to work less than thirty (30) hours per week. Regular part-time employees are eligible for benefits and must pay an additional premium for health care benefits. PTO and flex holiday hours accrue on a prorated basis according to an employee's scheduled work hours (Full-Time Equivalent (FTE) Status).

**As-Needed:** Employees called to work on an as-needed basis. As-needed employees are employed for an indefinite duration and must work less than one-thousand (1,000) hours per fiscal year. These employees may not have regularly scheduled hours and do not earn any benefits, unless otherwise required by law, but may become eligible for paid sick leave. In certain circumstances, CalOptima may provide additional benefits to "As-Needed" employees averaging thirty (30) or more hours per week and working beyond the ninetieth (90) calendar day of

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employment. If this occurs, the employee may be converted to either full-time or part-time, depending on the circumstances, for the duration of the "As Needed" period, not to exceed one-thousand (1,000) hours per fiscal year, with an offer of associated benefits to comply with applicable laws, including, but not limited to, the Affordable Care Act (ACA).

**Temporary Agency Workers:** Workers who have been hired by and are paid by a temporary agency for an assignment generally not expected to last more than one-thousand (1,000) hours per fiscal year. Temporary agency workers are not eligible for CalOptima benefits, with the exception of CalPERS retirement benefits, where applicable.

**Salaried (Exempt)**: Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.

**Hourly (Non-Exempt):** Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.

**Interns:** Paid interns are considered as-needed employees and must be enrolled in a college, or university, two (2) or four (4)-year degree program, an accredited vocational institution, or a graduate program, and may receive school credit for the internship. Unpaid interns shall not be deemed employees of CalOptima and must be enrolled in a college, or university, two (2) or four (4)-year degree program, an accredited vocational institution, or a graduate program, and must receive school credit for the internship.

CalOptima may change the employment classification/category of any employee at any time based on the nature of the employment assignment, operational efficiency, and to ensure compliance with applicable state and federal laws.

## Licenses and Certifications

When a required licensure and/or certification is/are mandated as part of a job position, or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). An employee is responsible for maintaining an active and current license and/or certification for the duration of his or her employment at CalOptima and providing proof of renewal to HR.

Employees shall notify HR immediately any time the employee knows, or has reason to know, of any prior action or action to be taken on the employee's required licensure and/or certification, or an event that occurs that could lead to such actions, including, but not limited to, pending, active, or resolved licensing board investigations, restrictions, allegations, revocations, suspensions, probation disciplinary actions, accidents, DUIs, etc. Failure to provide timely notification of such action(s) will be grounds for discipline, up to and including, termination.

See CalOptima Policy GA.8033: License and Certification Tracking

## Employment of Relatives

Management will exercise appropriate discretion in each case in the hiring and employment of relatives of current employees. "Relatives" are defined as any persons related by birth, marriage, domestic partner status, or legal

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guardianship including, but not limited to, the following relationships: spouse, child, step-child, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law and sister-in-law, or non-relatives of the same residence (housemate). If an employee knows or has reason to know that CalOptima is considering a relative of the employee for employment, that employee should make that fact known to the Human Resources Department.

Relatives of present employees may be hired by CalOptima only if:

- The applicant will not work directly for or directly supervising an existing employee; and
- A determination can be made that a potential for adverse impact on supervision, security, safety, or employee morale does not exist.

If the relationship is established after the employees' employment with CalOptima has commenced (*e.g.*, two (2) existing employees marry, become related by marriage, or become housemates), and a determination has been made that the potential for adverse impact does exist, the department head in conjunction with the Human Resources Director, shall make reasonable efforts to minimize problems of supervision, safety, security, or morale, through reassignment of duties, relocation, or transfer to another position for which one (1) of the employees is qualified, if such position is available. If no reassignment or transfer is practical, CalOptima will terminate one (1) of the employees from employment. The decision as to which employee will be reassigned, transferred, or terminated will be at the discretion of CalOptima with consideration of CalOptima's business needs. In certain situations, and at CalOptima's sole discretion, CalOptima may provide the employees with an opportunity to decide which employee shall be reassigned, transferred, or terminated from employment. If the employees do not make a decision within thirty (30) business days, CalOptima shall automatically reassign or transfer one (1) of the employees, if practical, or terminate one (1) of the employees from employment.

See CalOptima Policy GA.8051: Hiring of Relatives

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# Employee Performance and Responsibilities

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# Introduction to Employee Performance and Responsibilities

CalOptima strives to create an environment and culture where our employees can bring their knowledge, skills and talents to the forefront. We will treat our employees with respect and provide opportunities to be successful. CalOptima expects that each employee will strive to do his or her best as a CalOptima employee and that each employee will hold him or herself accountable for excellent performance, service, and results.

# Performance Evaluations

Evaluation of employees is a continuing process that takes place both formally and informally. Formal evaluations of performance and competence of regular employees shall take place following approximately ninety (90) calendar days of employment, based on the date of hire, transfer, or promotion, and a minimum of one (1) time per year thereafter as part of the annual review process.

During the formal performance review process, employees will have an opportunity to review their written performance evaluation and discuss it with their manager. If an employee questions a rating or comment included in the evaluation, they are encouraged to discuss it with their supervisor or manager at the time of the evaluation meeting. If the employee continues to have a concern, they may document it in the performance review system. Human Resources will be notified and will be available to help facilitate further conversation as needed.

# Initial Performance Review

CalOptima strives to hire qualified employees for the job. In order to ensure both the employee and CalOptima are meeting their respective expectations, an initial performance review is conducted following approximately ninety (90) calendar days of employment, based on the date of hire, transfer, or promotion, assuming the employee's employment has not otherwise been terminated. The manager will evaluate the employee's capabilities, work habits, compatibility with the job, interest in the job, and will discuss individual, department, and organizational expectations and performance. As an at-will employee, either party may terminate the employee's employment at any time, with or without cause, and with or without notice.

# Job Performance, Conduct, and Corrective Action

CalOptima employees are bound to one another and our organization by its core values of Collaboration, Accountability, Respect, Excellence, and Stewardship. CalOptima expects its employees to be committed to ethical conduct, excellent service, consistent attendance, positive teamwork, and compliance with CalOptima policies and procedures. Our reputation is fundamental to our continued success. Each of us has a personal responsibility to ensure that our conduct is true to that objective.

Employees are expected to abide by CalOptima's Code of Conduct and conduct themselves in an intelligent, mature, and responsible manner and in accordance with applicable laws, regulations, policies, and generally accepted work behaviors. Appropriate conduct is expected at all times while employees are on duty and/or on CalOptima property. Any violation of CalOptima policies, or any act or incident of improper behavior or conduct, may warrant corrective action, up to and including termination. In this regard, CalOptima has outlined some examples of undesirable behavior and/or performance issues that may result in corrective action, up to and including termination, which include, but are not limited to:

- Unsatisfactory work quality, or quantity;
- Failure to meet performance standards;
- Behavioral-based problems that impact productivity, quality, service, or teamwork;
- Excessive absenteeism, tardiness, or abuse of break and lunch privileges;

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- Creating conflict with co-workers, supervisors, members, or visitors;
- Damaging or unauthorized use of CalOptima-owned equipment;
- Failure to follow instructions, policies, regulations, laws, or CalOptima policies and procedures; and/or
- Failure to follow established safety regulations.

CalOptima strives to assist employees in understanding their performance expectations and in improving and preventing recurrence of undesirable behavior and/or performance issues. Employees are responsible for taking ownership in correcting their performance/behavior and in meeting their performance expectations.

CalOptima may, at its sole and complete discretion, initiate corrective action, where appropriate, in an effort to correct undesirable behavior and/or performance issues. The type of corrective action will depend on the nature of the offense, taking into consideration an employee's past performance and employment record, where applicable. Corrective action does not apply to all circumstances and will be employed on a case by case basis; however, CalOptima strives to assess corrective action in a fair and consistent manner.

As an at-will employee, CalOptima employees may be terminated at any time, with or without cause, and with or without advance notice. Employees are not guaranteed a right to a corrective action process prior to termination. CalOptima may skip one (1) or more steps, repeat certain steps, or skip the entire corrective action process altogether at CalOptima's sole and complete discretion. Serious performance, or behavioral, problems may result in immediate termination without corrective action prior to termination.

The corrective action process, when applied, is intended to give employees advance notice of problems with their conduct, or performance, in order to provide the employee with an opportunity to correct these problems. When used, the corrective action process may, in some but not all cases, include:

- Coaching discussion;
- Documented Counseling Memo;
- Written Warning;
- Performance Improvement Plan;
- Final Warning; and/or
- Termination.

Although one (1) or more of these steps may be taken in connection with a particular employee, no formal order or system is necessary.

Management may also place an employee on administrative leave with or without pay while HR conducts their investigation and/or final determination is pending and/or when there is a risk to CalOptima if the employee is permitted to continue in his or her role. The Human Resources Department shall work with management to address performance or behavioral issues and management actions.

See CalOptima Policy GA.8022: Performance and Behavior Standards

# Education and Training

CalOptima values the talent of its employees and encourages employees to continually develop their knowledge and skills to enhance their job responsibilities and prepare for future opportunities within the organization. CalOptima delivers mandatory courses, as designated by CalOptima leadership, Human Resources, the Office of Compliance, and departmental staff, as well as other optional training and personal development opportunities.

All mandatory courses and/or training sessions must be completed within the specified time frame and may require documentation that the employee passed the associated exam in order to be deemed completed. Mandatory trainings include, but are not limited to, compliance and regulatory requirements and information, which may be administered in person, online, and/or through other means of communication. Employees failing to complete the

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mandatory training and/or pass the associated exam within the stated time frame may receive corrective action, up to and including termination of employment.

## Open Door

CalOptima has an open-door approach that encourages employee participation in decisions affecting them and their daily responsibilities at CalOptima and/or the organizational operations. Employees who have work-related concerns or complaints, or have suggestions to improve operations, are encouraged to discuss these matters in an informal and professional manner with their immediate supervisor and/or any other management representative with responsibility for their department. If such concern or complaint arises from any particular incident, employees should report these issues to their immediate supervisor or another management representative with responsibility for their department as soon as possible after the event or incident that caused the concern.

If the employee feels he or she cannot resolve his or her concern or complaint with management within his or her department, then the employee should contact Human Resources. CalOptima believes that employee concerns are best addressed through open communication and that the majority of misunderstandings can be resolved through open dialogue. Employees are encouraged to pursue discussion of their work-related concerns until the matter is fully resolved.

Although CalOptima cannot guarantee that employees will be satisfied with the result, CalOptima will attempt in each instance to explain the result or resolution to the employee if the employee is not satisfied. CalOptima will also attempt to keep all such expressions of concern, the results of interviews or an investigation and the terms of the resolution confidential. However, in the course of looking into and resolving the matter, some dissemination of information to others may be appropriate and/or necessary. No employee will receive corrective action, or otherwise penalized, for raising a good-faith work-related concern in keeping with the open-door approach.

Employees who conclude their work-related concerns should be brought to the attention of CalOptima by written complaint and formal review may refer to the Internal Complaint Review process set forth in this handbook.

## Internal Complaint Review

CalOptima strives to maintain a safe, positive, and pleasant environment for our employees. Employees who encounter work-related problems are encouraged to follow the steps outlined below to resolve their issues.

*Step One: Immediate Supervisor*
Should an employee have a problem or complaint, he or she should try to resolve this issue with his or her immediate supervisor. In most instances, a friendly talk with a supervisor can quickly resolve a problem. The supervisor will evaluate the matter and work to provide a timely solution.

*Step Two: Department Head*
If the problem is not resolved in Step One, an employee can refer the problem in writing to his or her department head. The department head should schedule a meeting to discuss the issue with the employee and, in turn, provide a timely solution, where applicable.

*Step Three: Human Resources Department*
If, for any reason, an employee is dissatisfied with the decision of the department head, the employee can file a written complaint with the Human Resources Department. A representative from the Human Resources Department will review the complaint. When indicated, HR will meet separately with the employee and with others who are either named in the complaint, or who may have knowledge of the facts set forth in the complaint. CalOptima will attempt to treat all internal complaints and their follow-up review as confidential, recognizing, however, that in the course of reviewing, evaluating, and resolving internal complaints, some dissemination of information to others may be necessary. On completion of the review, the Human Resources Department will discuss any actions, or resolutions with the employee.

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*Step Four: Appeal*
If the complaint is not resolved to the employee's satisfaction, the employee may submit a written request for review of the complaint to CalOptima's Executive Director of Human Resources. On completion of the appeal review, the employee will receive an oral or written summary of the review. Decisions resulting from appeal reviews by CalOptima's Executive Director of Human Resources will be final.

No employee will be retaliated or discriminated against in any way because he or she made a complaint in compliance with this process. Nothing in this Internal Complaint Review is intended to alter the at-will nature of employment.

# Attendance, Tardiness, and Reporting Absences

CalOptima counts on each employee's attendance and punctuality to provide efficient and consistent service to our members. We expect employees to report to work on time, observe the time limits for break and meal periods, and not leave work earlier without prior approval from their immediate supervisor. Regular and consistent attendance is an essential function of all job positions at CalOptima.

An employee's schedule is determined by the employee's immediate supervisor or the department supervisor based on CalOptima's core business hours to ensure coverage, where applicable.

Departments may establish guidelines for scheduling and reporting absences or time away from work that meets their specific business needs. If department specific guidelines have been established, employees are to follow the procedures of their respective department to the extent such procedures do not conflict with applicable laws. In the absence of a department-specific guideline or directive on attendance, a department shall adhere to the guidelines included in CalOptima Policy GA.8059: Attendance and Timekeeping.

If an employee is going to be absent or tardy, he or she must provide timely notice to his or her supervisor *before* his or her scheduled shift time. If the supervisor cannot be reached, the employee is expected to leave a message on the supervisor's voicemail or notify the department head or other designated department contact. Employees must provide the reason for the absence and the expected date of return. Employees must call in each day they will be absent or tardy, unless they are on a lengthier, pre-approved medical leave. Frequent tardiness or absenteeism will result in corrective action, up to and including termination. If an employee is absent for four (4) consecutive days, or more, of personal and unprotected sick time, a doctor's note is required on the first day back.

*Authorized Absence*
An authorized absence occurs when all four (4) of the following conditions are met:

1. The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to his or her immediate supervisor or designee prior the commencement of his or her shift;
2. The employee provides an acceptable reason to his or her immediate supervisor or designee;
3. Such absence request is approved by his or her immediate supervisor or designee;
4. The employee has sufficient accrued PTO to cover such absence or the supervisor waives this requirement because the employee has not yet accrued sufficient PTO.

The employee's immediate supervisor may waive the notice requirement when it is warranted by the particular circumstances involved; for example, when an employee is unexpectedly taken ill and cannot call in a timely manner. Failure to meet these requirements may result in corrective action, up to and including termination, depending on the surrounding circumstances.

Absences of more than five (5) consecutive scheduled work days for an illness or pre-planned surgery must be submitted to and approved by HR.

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*Unauthorized Absence*
An employee is considered to be on an unauthorized absence when one (1), or more, of the four (4) conditions mentioned above are not met. If an employee fails to provide a doctor's note after four (4) consecutive days, or more, on personal and unprotected sick time, then the days are considered unauthorized absences.

Unauthorized absences may result in corrective action, up to and including termination, depending on the surrounding circumstances. In addition, an employee is considered to have resigned when the employee fails to report to work without giving notice to and/or receiving authorization from his or her immediate supervisor for three (3) consecutive scheduled work days, unless the situation makes this impossible.

*Frequent or Prolonged Absenteeism or Tardiness*
Frequent or prolonged absenteeism or repeated tardiness, even when authorized, may result in corrective action, up to and including termination. Absences from work that qualify and are approved under CalOptima's leave of absence policy will not count toward excessive absenteeism.

See CalOptima Policy GA.8059 Attendance and Timekeeping

## Drug-Free and Alcohol-Free Workplace

CalOptima strives to maintain a workplace that is free of drugs and alcohol and discourages drug and alcohol abuse by its employees. CalOptima has a vital interest in maintaining a safe and productive work environment for its employees, members, and those who come into contact with CalOptima. Substance abuse is incompatible with the mission and interest of CalOptima. In accordance with federal law, marijuana and other cannabis products fall under the category of "illegal drugs". Employees who are under the influence of drugs and/or alcohol in the workplace can compromise CalOptima's interests, endanger their own health and safety and the health and safety of others, and can cause a loss of efficiency, productivity, or a disruptive working environment.

The following rules and standards of conduct apply to all employees either on CalOptima's property, working offsite, or on CalOptima business. Behavior that violates CalOptima policy includes:

- The unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance;
- Possession, or use, of an illegal, or controlled, substance, or being under the influence of an illegal, or controlled, substance while on duty, or on/in CalOptima property, except where the controlled substance is lawfully prescribed and used consistent with a doctor's authorization;
- Abuse of a legal drug or the purchase, sale, manufacture, distribution, dispensation, or any legal prescription drug in a manner inconsistent with law;
- Operating a CalOptima owned or leased vehicle or conducting CalOptima business in a personal vehicle while under the influence of alcohol, illegal drugs, or controlled substance(s); and/or
- Distribution, sale, or purchase of alcohol and/or an illegal, or controlled, substance while on on-duty or on or in CalOptima Property.

Violation of these rules will not be tolerated, and CalOptima shall take appropriate actions including, but not limited to, employee corrective action, up to and including termination. CalOptima also may bring the matter to the attention of appropriate law enforcement authorities and/or professional licensing authorities.

CalOptima reserves the right to conduct searches of CalOptima property or employees and/or their personal property, and to implement other measures necessary to deter and detect abuse of this policy. CalOptima asserts its legal right and prerogative to test certain employees for substance abuse. These employees may be asked to submit a medical examination and/or to submit to urine testing for illegal drugs, controlled substances, or alcohol under the following circumstances:

- Employees in certain positions are required to pass a pre-employment urine drug test.

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- Employees in certain positions may be subject to random drug testing.
- If the CalOptima employee is involved in a traffic accident and there is reasonable suspicion of the involvement of drugs and/or alcohol.
- If an employee's supervisor, manager, Human Resources representative or other leader suspects an employee is under the influence of drugs and/or alcohol and observes two (2) or more symptoms.

Employee acceptance of medical examinations and testing, when requested by CalOptima for one (1) of the reasons set forth above, is a mandatory condition of employment. Refusal to submit to such medical examinations and tests constitutes a violation of CalOptima's policy and is grounds for corrective action, up to and including immediate termination of employment.

Any employee who is using prescription, or over-the-counter drugs, that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting, or resuming, work. Any prescription medication, which must be taken while at work, should be kept in the original prescription container and used in accordance with the prescribing physician's instructions. CalOptima reserves the right to require written medical certification of the employee's ability to perform his or her duties while taking any prescribed medication.

All CalOptima employees who provide health care services and personal care services to CalOptima members may be subject to random drug testing. This shall include any employee who operates a CalOptima owned, or leased, motor vehicle.

All CalOptima employees who have face-to-face interaction in the residence of a member, or prospective member, and provide health care services, or personal care services, such as nurses in the field, may be subject to random drug testing.

Employees are required to report any drug and/or alcohol related convictions occurring outside of the workplace to CalOptima within five (5) calendar days of such conviction. This information may subject the employee to corrective action, random testing requirements, referral to the Employee Assistance Program (EAP), and/or may be reported to the appropriate licensing authority.

See CalOptima Policy GA.8052: Drug-Free and Alcohol-Free Workplace

## Employee Access to Personnel Records

Employees of CalOptima, in certain instances, are given permission to have access to information in their own personnel files. Employees may request access to this information at a reasonable time and place by appointment, usually during business hours in the Human Resources Department, unless another time or place is mutually agreed upon. CalOptima reserves the right to monitor the inspection of the file to ensure that nothing is removed, destroyed or altered, and that it is returned to its proper location. The right to inspection does not include certain records including, but not limited to, records relating to investigations, letters of reference, and/or records obtained prior to the employee's employment, or were obtained in connection with a promotion, or transfer. Employees requesting access to their own personnel record may review such records during their own personal time, either during scheduled break times, lunch, prior to or at the end of employees' work days, or on employees' scheduled days off, depending on the availability of the Human Resources Department.

## Change of Employee Personal Information

Each employee is required to report promptly any change in his or her status and/or personal information to the Human Resources Department as soon as it occurs, but in no event beyond thirty (30) calendar days. Such changes include name, address, marital status, telephone number, number of dependents, person(s) to be notified

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in case of emergency, physical limitations, beneficiary, etc. This information may affect deductions, health coverage, and many other aspects of employment. Status changes may be made through the Employee Self-Service module on the CalOptima InfoNet.

It is vitally important to notify the Human Resources Department within thirty (30) calendar days of a status change such as marriage, divorce, birth or adoption of a child. Notification and requests to add/delete dependents must be submitted in writing to the Human Resources Department. Failure to notify Human Resources of these qualifying events may preclude, or delay, changes in eligibility for insurance.

## Confidential Information

CalOptima has a particular interest in protecting its proprietary, private, and/or confidential information. CalOptima property includes not only tangible property, like desks, file cabinets and computers, but also intangible property such as information. Proprietary information includes all information obtained by CalOptima employees during the course of their work including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel review, or social security number. Confidential information is any CalOptima information that is not known generally to the public including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, DHCS reimbursements, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

CalOptima employees, or agents, may not reveal, disclose, divulge, or make accessible, proprietary, private, and/or confidential information belonging to, or obtained through, the employee's affiliation with CalOptima to any person, including relatives, friends, and business and professional associates, other than persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. Employees may not disclose or use proprietary, or confidential, information, except as their jobs require. Inappropriate use, unauthorized copy and transfer, attempted destruction, the destruction or disclosure of confidential, private, or proprietary information obtained through the employee's affiliation with CalOptima will subject an employee to corrective action, up to and including termination and possible legal recourse.

*Confidentiality and the Health Insurance Portability and Accountability Act (HIPAA)*
CalOptima is committed to protecting the confidential, sensitive, and proprietary health information of our members and employees. HIPAA addresses the need to protect and safeguard our members' information. This includes making sure electronic health information is secure, taking precautions to safeguard member files, and following all other HIPAA regulations regarding Protected Health Information (PHI).

An employee should not store PHI on CDs, DVDs, external electronic storage devices, mobile phones, external email accounts and cloud storage without proper authorization from the Information Services (IS) Department. Also, s*ensitive data such as PHI should not be stored on nor sent to, from or through any employee's personal consumer email service. Examples include Yahoo!, live.com, Gmail, Hotmail, AOL, or any other non-CalOptima email system.*

Please contact our Privacy Officer for more information. Failure to follow HIPAA regulations and CalOptima policies concerning protection of member and employee files and information may subject an employee to corrective action up to and including termination and possible legal recourse.

See CalOptima Policies GA.8050: Confidentiality, GA.5005a: Use of Technology Resources, IS.1201: Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls, IS.1202: Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls, and IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI).

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# Compliance Program

CalOptima maintains a comprehensive Compliance Program, part of which is a plan to detect, investigate, and report fraud, waste, and abuse in any and all of the CalOptima programs. CalOptima employees are required to report any and all suspected, or actual, cases of fraud, waste, and abuse to the CalOptima Office of Compliance. An employee can file a report anonymously by contacting the CalOptima Compliance and Ethics Hotline at 877-837-4417. Employees can also file a Suspected Fraud or Abuse Referral Form with the Office of Compliance, which is available on the CalOptima InfoNet. In addition, employees are always welcome to speak with their supervisor or the Compliance Officer at any time with any concerns they may have. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation protections.

The CalOptima Code of Conduct provides that CalOptima employees are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to any CalOptima program, its policies and procedures, and its Compliance program. Failure to comply with the Compliance program, including CalOptima's Code of Conduct, may lead to disciplinary action. Discipline, at CalOptima's discretion, may include corrective action or may lead to direct termination in accordance with CalOptima policies. In addition, failure to comply with CalOptima's Compliance Program and Code of Conduct may result in the imposition of civil, criminal, or administrative fines on the employee and/or CalOptima, which may include exclusion from participation in federal and/or state health care programs.

See CalOptima Policies HH.2014Δ: Compliance Program and HH.2028Δ: Code of Conduct

# Code of Conduct

CalOptima maintains a strict Code of Conduct governing employee conduct, as well as ethical behavior related to and/or concerning work-related decisions. CalOptima expects all employees to follow this code and to report situations in which they become aware of circumstances and/or behaviors which do not live up to CalOptima's standard. In order to discourage inappropriate conduct and/or illegal activities and to protect member confidentiality, CalOptima maintains the CalOptima Compliance and Ethics Hotline at 877-837-4417 to provide an opportunity for all employees to report unethical conduct. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation protections.

The CalOptima Code of Conduct provides that CalOptima employees are encouraged to speak up and report any instance in which unethical behavior occurs as outlined in the Code of Conduct policy. Failure to comply with the Code of Conduct may lead to corrective action, up to and including termination.

See CalOptima's Code of Conduct

# Dress Code

CalOptima has adopted a Business Casual Attire Dress policy as the standard attire from Monday through Thursday. Employees must choose clothing that communicates professionalism. Business casual includes CalOptima logo attire.

There may be times that management may require employees to dress in customary business professional attire including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the organization at an outside community function.

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The following dress guideline outlines the general workplace standard that must be followed by CalOptima employees. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees based upon job duties.

**Business Casual**: Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be compatible with a professional environment and clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards, and no more than three and one-half (3 ½) inches in height. In all cases, management within each respective department will define "appropriate" business casual attire.

When dressing in business casual, we ask that employees not wear jeans (or any type of denim or any color jeans or overalls), spaghetti strap shirts casual tank tops, halter tops or tube tops, see-through clothing, short skirts (where the length and/or fit is incompatible with a professional environment), any type of shorts, casual sandals (such as flip flops, slide sandals or beach attire), tennis or canvas shoes, any footwear without a back or backstrap, capri pants (unless part of a professional dress suit or two-piece business outfit), leggings or stretch pants, clothing displaying any written words or symbols (with the exception of CalOptima logo attire, or brand names, or symbols), clothing that reveals undergarments or parts of the body incompatible with a professional setting, or any type of hat, unless the employee obtains prior approval from Human Resources.

**CalOptima Logo Attire** (Monday–Friday): CalOptima logo attire includes sweaters, dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants, or khaki pants, in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans or capri pants from Monday through Thursday.

**Casual Attire** (Friday): Casual attire is a benefit permitted only on Fridays, unless otherwise specified. As with business casual attire, casual attire should be compatible with a professional environment and neat in appearance and in good repair, with no tears, or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals with a backstrap, tennis shoes, or other casual clothing in good condition. Leggings are acceptable only when worn with a dress, or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire.

Casual attire does not include: any type of jogging or sweat suits/sweatpants; spaghetti strap tops, casual tank tops, halter tops, or tube tops; casual sandals (such as flip flops, slide sandals, or beach attire); any footwear without a back or backstrap; house slippers; yoga or workout pants; see-through clothing; ripped jeans (including shredded jeans); any type of shorts; clothing that exposes the stomach area or other parts of the body incompatible with a professional environment; clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos; or hats, unless prior approval from Human Resources is given.

As a benefit, employees may dress in casual attire every Friday and every year during the following times, unless otherwise specified:

- The week of Thanksgiving;
- The period between Christmas and New Year's Day;
- The period between Memorial Day and Labor Day; and
- National Customer Service Week (First week of October).

Employees may be subject to corrective action, up to and including termination, for violations of CalOptima's dress code policy.

See CalOptima Policy GA.8032: Employee Dress Code

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# Conflict of Interest

Employees are expected to devote their best efforts and attention to the full-time performance of their jobs. Employees are expected to use good judgment, to adhere to high ethical standards, and to avoid situations that create an actual or potential conflict or the appearance of a conflict between the employee's personal interests and the interests of CalOptima.

Employees unsure as to whether a certain personal or non-CalOptima transaction, activity, or relationship constitutes a conflict of interest should discuss it with their immediate supervisor, or the Human Resources Department for clarification. Any exceptions to this guideline must be approved, in writing, by CalOptima's Chief Executive Officer (CEO).

While it is not feasible to describe all possible conflicts of interest that could develop, some of the more common actual, or potential, conflicts, which employees should avoid, include the following:

1. Accepting personal gifts or entertainment from current or potential providers, members, or suppliers totaling more than five dollars ($5) in a calendar year from any single source;
2. Working for a current or potential provider, contractor, vendor, member, or supplier, association of contractors, vendors, providers, or other organizations with which CalOptima does business or which seek to do business with CalOptima, except when it is determined that the nature of the job does not create a conflict;
3. Engaging in self-employment in competition with CalOptima;
4. Using proprietary or confidential CalOptima information for personal gain, or the gain of others, or CalOptima's detriment;
5. Having a direct or indirect financial interest in or relationship with a current or potential provider, supplier, or member; except when it is determined that the nature or financial interest does not create a conflict
6. Using CalOptima assets or labor for personal use;
7. Acquiring any interest in property or assets of any kind for the purpose of selling or leasing it to CalOptima; and/or
8. Committing CalOptima to give its financial, or other, support to any outside activity, or organization.

If an employee, or someone with whom an employee has a close relationship (a family member or close companion), has a financial, or employment, relationship with a current, or potential, provider, contractor, vendor, supplier, or member, the employee must disclose this fact in writing to the Human Resources Department. Employees should be aware that if they enter into a personal relationship with an employee of a current, or potential provider, supplier, or member, a conflict of interest might exist, which requires full disclosure to CalOptima.

All CalOptima employees are required to promptly report any and all non-CalOptima job positions, positions held on non-profit/charitable organizations, and/or their affiliations or interests in job-related businesses, or organizations to the Human Resources Department.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Supplement to Form 700 upon hire, annually, and upon termination of employment. The Human Resources Department coordinates this activity with the Clerk of the CalOptima Board.

Failure to adhere to this guideline, including failure to disclose any outside positions, conflicts or to seek an exception, may result in corrective action, up to and including termination of employment and/or criminal, civil, or administrative action.

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See CalOptima Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima.

## Guests

Due to the confidential nature of CalOptima's operations, employees are discouraged from having visitors at work, unless necessary, or related to performance of job duties. Children of employees are not allowed on the premises during working hours unless attending a formal CalOptima sponsored function or unless previously authorized by the employee's management during the employee's non-working hours (*e.g.,* lunch break, PTO day off, etc.).

All guests must register at the reception desk in the lobby and obtain a guest badge. Guests are not permitted to walk around CalOptima's secured areas unaccompanied. Employees shall not permit guests to access CalOptima facilities for any unauthorized purpose and/or to perform personal business, unless as part of a formal CalOptima sponsored function.

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# Introduction

CalOptima is proud of the comprehensive benefits package we provide to our employees. This section of the handbook is designed to acquaint employees with some of the more significant features of CalOptima's employee benefits. It is important to remember that more detailed information is set forth in the official plan documents, summary plans descriptions and/or group policy contracts that govern the plans. Accordingly, if there is any real or apparent conflict between the brief summaries contained in this manual and the terms, conditions, limitations or exclusions of the official plan documents, the provisions of the official plan documents will control over these brief summaries. Employees are welcome and encouraged to review the official plan documents, available in the Human Resources Department, for further information.

# Workers' Compensation

CalOptima, in accordance with state law, provides insurance coverage for employees in case of work-related injuries. The cost of this insurance is completely paid for by CalOptima. The Workers' Compensation benefits provided to injured employees may include:

- Medical, surgical, and hospital treatment;
- Partial payment for lost earnings that result from work-related injuries; and/or
- Rehabilitation services to help injured employees return to a suitable employment.

Workers' Compensation is a type of accident and injury insurance that compensates an employee for lost wages, medical expenses and permanent impairment as a result of a work-related injury or illness. Injured or ill employees are entitled to receive the following benefits when they sustain an injury or illness "arising out of and in the course of their employment":

- Medical Care,
- Temporary Disability Benefits,
- Permanent Disability Benefits,
- Supplemental Job Displacement Benefits if they are not able to return to their regular work; and/or
- Death Benefits.

When an employee reports a work-related injury or illness, he or she will be sent to a designated clinic within the Medical Provider Network (MPN) set up by our workers' compensation carrier. Employees may see their own doctor only if their doctor has previously been designated as the treating physician and this authorization has been submitted to Human Resources at least 30 days prior to an injury or onset of illness. All appointments related to medical treatment must be coordinated through the Workers' Compensation insurance company and the Human Resources Department.

Temporary disability benefits are payments for lost wages that are paid to the injured or ill employee while they are recovering and are unable to work. Temporary disability benefits are based on 2/3 of the employee's average weekly earnings up to a statutory cap (set by the State legislature). They are paid every 14 days for a total of 104 weeks maximum. No payments are made for the first 3 days (waiting period) unless the disability continues for more than 14 calendar days, the employee is hospitalized or is the victim of a criminal assault. Paid Time Off (PTO) may be used for the 3-day waiting period.

Employees are required to report all on-the-job injuries to their supervisor and Human Resources immediately, regardless of how minor the injury may be. Managers who are aware of a workplace injury or illness are required to notify Human Resources immediately. CalOptima is legally required to report serious injuries, or illnesses, including the death of an employee, within eight (8) hours of the incident and/or accident.

See CalOptima Policy GA.8041: Workers' Compensation Leave of Absence

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# Paid Time Off and Workers' Compensation

Workers' Compensation does not usually cover absences for medical treatment, follow-up doctor's appointments, physical therapy appointments, and/or other appointments related to a Workers' Compensation claim, or injury. Employees returning to work, or who are still working after a work-related injury or illness under the Workers' Compensation Act, are required to coordinate with their supervisor to use accrued PTO, or make up time away from work, consistent with CalOptima's timekeeping requirements, for follow-up medical appointments. Appointments should be scheduled in a manner that provides the least disruption to the employee's normal work schedule. Injured or ill employees are encouraged to document all mileage incurred for medical appointments and submit to the workers' compensation carrier for reimbursement. Employees who do not have sufficient PTO accruals may take unpaid time off for follow-up medical appointments.

# Core Health Benefits

The benefits CalOptima offers its employees are an important part of a total compensation package. Such benefits, like health and life insurance, would be significantly more expensive if employees had to purchase them privately. CalOptima's benefits are regularly reviewed to ensure that they are competitive with those offered by other public agencies and organizations in Southern California.

All regular full-time, regular part-time, and qualifying as-needed employees and, if elected, their eligible family members, are eligible for health insurance benefits beginning the first day of the month following the employee's date of hire. However, if the date of hire is on the first of the month, health insurance benefits begin effective on the hire date. Eligible family members include: spouses, registered domestic partners, and dependent children under the age of twenty-six (26), or disabled dependent. Documentation certifying eligibility is required. Coverage will commence on the first (1st) of the month following the employee's date of hire unless the date of hire is the first (1st) of the month.

Employment eligibility requirements and enrollment change information is available in the individual Summary of Benefits and Coverage (SBC), Summary Plan Descriptions (SPD), and other benefits booklets. Questions regarding any of CalOptima's benefits should be directed to the Human Resources Department.

Once enrolled, the employee's elections will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Many of the deductions taken on CalOptima employee health benefits are taken on a pre-tax basis since CalOptima participates in a Flexible Benefits Plan (Cafeteria Section 125 Plan). Unless the employee has a qualifying event, no changes can be made to the employee's elections after the open enrollment period has ended. Employees are solely responsible for making sure the employee's elections are accurate. For this reason, changes to medical, dental, vision, health, or dependent care flexible spending accounts (FSA) may only be made with the submission of supporting documentation that provides substantiation of the qualifying event. Some examples of qualifying events include, but are not limited to marriage, divorce, birth/adoption of child, over-age dependent, and change of spouse's employment. If one of these events occurs, the Human Resources Department must be contacted within thirty (30) days to make a change. Otherwise, employees are required to wait until the next annual open enrollment period, usually held in October of each year, to make any changes to their elections. The effective date for qualifying event changes can only be made prospectively, not retroactively.

When health benefits coverage terminates due to an extended personal leave of absence, or termination of employment with CalOptima, employees may be eligible under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) to continue enrollment for a period of time. Additional information is mailed to terminated employees from a third-party COBRA administrator following the last day of employment.

Upon an employee's separation from CalOptima, health insurance benefits continue through the end of the month that he or she terminates in. The employee is responsible for his or her share of the costs for health insurance benefits for the entire month, and appropriate deductions will be included in the employee's final paycheck.

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Below is a list of core benefits available to eligible full-time and part-time regular employees. The employee premiums, deductions from payroll for these benefits, vary depending on the employee's employment classification and annual modifications based on changes in premiums from our carriers. CalOptima reserves the rights to modify, change, eliminate, or add to the following list of benefits at its sole discretion:

**Health —** CalOptima provides different options for affordable HMO and PPO health plans that include a broad network of medical groups and hospital access with a very reasonable co-pay structure for office visits and pharmacy benefits. A High Deduction Health Plan (HDHP), inclusive of employer contributions, and a Health Savings Account (HSA) are available at the employee's election.

**Dental** — Comprehensive dental plans that include services such as orthodontia benefits and preventive dental care visits are available to CalOptima employees.

**Vision** — CalOptima's vision plan design allows for eye examinations, glasses, and contact lenses.

**Life and AD&D** — Full-time regular employees receive a $50,000 life and accidental death and dismemberment (AD&D) insurance policy, or one (1) times the employee's basic annual earnings, whichever is higher, with a maximum amount of $400,000. Part-time regular employees receive a $25,000 life and AD&D insurance policy, or one (1) times their basic annual earnings, whichever is higher.

**Short-Term Disability** — An employee with a qualifying disability/condition may receive short-term disability benefits, which pays seventy percent (70%) of an employee's regular wages for a period of time following a waiting period. This benefit is a substitute for state disability benefits as CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

**Long-Term Disability** — An eligible employee with a qualifying disability/condition may receive long-term disability benefits, which pays sixty percent (60%) of regular wages until normal retirement age, as long as the employee meets the definition of disability. This benefit is used in lieu of state disability benefits since CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

**Employee Assistance Program (EAP)** — This free and confidential resource provides easy and accessible services to employees (and some extended family members) for behavioral health issues such as: counseling for relationship issues, emotional well-being, legal and financial assistance, substance abuse, as well as workplace challenges.

CalOptima also offers additional voluntary benefits to eligible employees. These voluntary optional benefits may include benefits such as: additional voluntary life and AD&D insurance, whole life and critical illness insurance plans, legal plans, and flexible spending accounts (FSA). All voluntary benefit premiums are one hundred percent (100%) paid for by the employee.

## Retirement Benefits

**CalPERS (California Public Employees Retirement System) Defined Benefit Plan** — CalOptima has contracted with CalPERS instead of participating in Social Security. Regular full-time and regular part-time employees are automatically enrolled into the CalPERS plan upon date of eligibility, which is usually the employee's date of hire. In particular cases, qualifying as-needed and temporary employees, who were previously enrolled in CalPERS may also be enrolled into CalPERS upon date of eligibility. To be eligible for service retirement with CalPERS, employees considered classic CalPERS members must be at least age fifty (50) and have a minimum of five (5) years credited service. For new employees hired on, or after, December 1, 2013, who do not have reciprocal rights, the minimum retirement age for new hires has been increased to fifty-two (52); however, the years of credited service remains five (5). Classic CalPERS members (those that established membership prior to January 1, 2013) are enrolled in the 2 percent @ 60 benefit formula. New members (those

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that established membership on or after January 1, 2013) are enrolled in the 2 percent @ 62 formula. Basic CalPERS plan information is provided to employees during their first month of employment.

**PARS (Public Agency Retirement Services) Defined Contribution Plan** — This supplemental retirement plan is a 401(a) tax-qualified multiple employer trust. All regular full-time and regular part-time employees are automatically enrolled, and a contribution is made by CalOptima. There is a vesting requirement based on quarters of service. Contributions are automatically invested into a life-cycle mutual fund and professionally managed; however, employees have the option to self-direct fund investments in their account. Basic plan information is provided to employees during their first month of employment.

**457b Deferred Compensation Plan** — A 457b voluntary plan is also offered as a way to save for retirement. All deposits to this plan are made by the employee. The annual IRS regulated contribution limit generally increases each year and catch-up contribution provisions are available for those who are age fifty (50) and above. The employee determines his or her contribution amount as well as his or her investment allocation. A licensed financial advisor will provide plan related information, usually within the first month of employment.

**Social Security Retirement** — CalOptima does not participate in Social Security. All regular full-time and regular part-time employees are considered Social Security tax exempt and pay into CalPERS instead of Social Security. Upon hire, Human Resources will explain how CalPERS and Social Security work together. The Human Resources Department will inform employees about two (2) important Social Security provisions: Government Pension Offset and Windfall Elimination Provision. As-needed employees are not eligible for CalPERS membership, unless certain conditions apply, therefore, by default, unless they are eligible for enrollment in CalPERS, they are the exception to this rule and will see a FICA/Social Security deduction taken from their payroll, and subsequently are only authorized to work up to one thousand (1,000) hours per fiscal year on a general basis.

**Medicare** — The employee and CalOptima each contribute their proportionate share to Medicare.

## Paid Time Off (PTO)

CalOptima provides paid time off (PTO) benefits to all eligible employees to enable them to take time off from work for activities such as rest, recreation, recovery from injury and illness or other personal activities CalOptima believes this time is valuable for employees in order to enhance productivity and to make the work experience more personally satisfying. CalOptima provides employees with additional hours of PTO as years of service are accumulated.

Full-time, part-time, and limited-term employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use PTO hours for vacation, preventive health or dental care, or care of an existing health condition of the employee, or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, Child-Related Activities, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. CalOptima encourages all employees to maintain a work-life balance by utilizing PTO benefits for rest and recreation throughout the year.

When available PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's annual PTO accrual rate. When an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Each year each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year.

Eligible employees accrue PTO based on their classification as exempt, or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and years of continuous services in accordance with the

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accrual schedule below. PTO begins accruing from the date of hire. PTO accruals will only accrue in conjunction with CalOptima payroll and will be prorated based on hours earned.

**Annual Paid Time Off Benefits Accrual Schedule**

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period.

**Non-Exempt Employees:**

| Years of Continuous Service | Hours of PTO Accrued (Biweekly pay period) | Annual Hourly Accrual | Days Accrued per Year |
|---|---|---|---|
| 0–3 | 5.54 | 144 | 18 |
| 4–10 | 7.08 | 184 | 23 |
| 11 + | 8.62 | 224 | 28 |

**Exempt Employees:**

| Years of Continuous Service | Hours of PTO Accrued (Biweekly pay period) | Annual Hourly Accrual | Days Accrued per Year |
|---|---|---|---|
| 0–3 | 7.08 | 184 | 23 |
| 4–10 | 8.62 | 224 | 28 |
| 11 + | 10.15 | 264 | 33 |

Scheduling of PTO is to be done in a manner compatible with CalOptima's operational requirements. In order to minimize the impact of an employee's absence, planned time off should be submitted by an employee to his or her immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO.

PTO Donation Program: The Human Resources Department administers a PTO Donation Program . Employees may donate accrued PTO hours to assist another CalOptima employee ("Recipient Employee") when a Recipient Employee qualifies as having a Catastrophic Illness. Donations are voluntary and donors will remain anonymous to the Recipient Employee.

See CalOptima Policy GA.8018: Paid Time Off (PTO)

# Paid Sick Leave

CalOptima provides employees who are eligible to accrue PTO a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Healthy Workplaces, Healthy Families Act of 2014 (Act), effective July 1, 2015. For all other employees who are not eligible to accrue PTO, as-needed, per diem, or temporary employees may become eligible for paid sick leave if the employee works thirty (30), or more, days within one (1) year from the start of their date of employment. Twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave is provided only to eligible employees who do not accrue PTO.

Upon satisfying a ninety (90)-day employment period, employees may use accrued sick leave for preventative care or diagnosis, care, or treatment of an existing health condition of the employee, or the employee's family member, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

Upon termination, resignation, retirement, or other separation from employment, CalOptima will not pay out employees for unused paid sick leave time accrued under the Act. If an employee separates and is then rehired by CalOptima within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to

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the Act's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

See CalOptima Policy GA. 8018: Paid Time Off (PTO)

# Holidays

CalOptima generally observes the following holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day and the Friday after Thanksgiving
- Christmas Day
- One (1) Flex Day (accrues on January 1st)

A holiday that falls on a Saturday or Sunday is usually observed on the preceding Friday, or the following Monday. Holiday observances will be announced in advance. CalOptima may, in its discretion, require an employee to work on scheduled holidays. If a non-exempt employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday pay in addition to his or her regular compensation for the hours of actual work performed. From time to time, at the discretion of the CEO, the CEO, or his or her designee, may authorize managers, at their discretion, to release employees early, up to a maximum of two (2) hours, with pay, on the work day immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of employees early is intended to benefit only those employees who are working on the work day immediately preceding a holiday. Employees who are on PTO on the day employees are permitted to leave early are not entitled to any credit or future early release.

**Flex Holidays**

Employees will receive a maximum of one (1) flex holiday (maximum of eight (8) hours, prorated based on scheduled work hours) on January 1st of each year; however, CalOptima reserves the right to assign a specific date for the flex holiday for business reasons and/or needs. Limits are imposed on the number of flex holiday hours that can be maintained in the employee's flex holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an employee's flex holiday account as of January 1st of each year. In the event that available flex holiday hours are not used by the last pay period of the calendar year, employees may carry unused flex holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on the scheduled work hours. If an employee reaches the maximum amount of twelve (12) hours on January 1st, prorated based on the scheduled work hours, the employee will stop accruing flex holiday hours. Flex holiday hours are not eligible for annual cash out applicable to PTO hours. However, if an employee separates from CalOptima and has unused flex holiday hours, the unused flex holiday hours for that calendar year will be paid out at the same time and in the same manner as unused PTO hours upon termination.

**Eligibility**

Regular full-time and regular part-time employees who are regularly scheduled to work twenty (20), or more, hours per week are eligible for holiday benefits and flex holiday accrual hours but will be prorated based on their full-time or part-time status at the time of the holiday. To receive holiday pay, employees must work, or be paid for the regularly scheduled workdays preceding and following the CalOptima holiday. If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday, and the holiday pay will be prorated based on the

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employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

See CalOptima Policy GA.8056: Paid Holidays

## Education Reimbursement

CalOptima believes in the development and growth of its employees. In order to encourage developmental progression, CalOptima provides an Education Reimbursement Program to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements. Education Reimbursement is available to all eligible regular full-time, or part-time, employees who have completed their initial one hundred eighty (180) days of continuous employment, are in good standing, and are eligible to participate.

Courses eligible for tuition reimbursement must be either part of an accredited college degree program, or provided by credible institutions that meet the following conditions:

1. Educate the employee in concepts and methods in their present assignment.
2. Help prepare the employee for advancement to other positions available within CalOptima.

Continuing education courses that provide credit towards renewal of a licensure and/or certification may be eligible for reimbursement under this policy. Seminars, conferences, or business meetings that do not result in certification or credit towards a licensure and/or certification are not covered. Seminars, conferences, and business meetings may be eligible for reimbursement through CalOptima's Travel and Training program. Effective July 1, 2019, the costs of new or renewed licensures or certifications are not covered under CalOptima Policy GA.8036: Education Reimbursement.

Attendance at outside education courses and/or programs, whether required by CalOptima, or requested by individual employees, requires prior written management and Human Resources approval. Details of the program and how to apply for reimbursement are available in the Human Resources Department. The Human Resources Department shall be responsible for developing, administering, and maintaining the program. In order to be reimbursed, eligible employees must satisfactorily complete a work-related course or program, or complete a professional certification offered by an accredited school, community college, college, university, or other recognized professional organization, or learning institution. Miscellaneous expenses such as parking, exams, education subscriptions, books, and supplies are not covered and shall not be reimbursed.

See CalOptima Policy GA.8036: Education Reimbursement

## COBRA

CalOptima complies with the provisions and requirements of both the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Both Acts provide for continued coverage of an employee's, his or her spouse's, and his or her dependents' health benefit coverage in the event that the employee is no longer eligible for CalOptima's group health coverage. Please see the Human Resources Department for additional information.

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19 **CalOptima Property**
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# Employer Property

Cubicles, desks, computers, vehicles, and other CalOptima owned, or leased, items are considered CalOptima property and must be maintained according to CalOptima's policies, rules, and regulations. CalOptima property must be kept clean and in good condition. Decorations in an employee's work space should fit with the overall professional business atmosphere CalOptima projects and should take into consideration the needs and sensitivities of our members, providers, fellow employees, and the public.

Data maintained on CalOptima's systems, including employee work-product, are CalOptima property, and employees should refrain from downloading any CalOptima work product, particularly confidential and proprietary information, including but not limited to, documents the employee may have developed or prepared that contain PHI, during the course of employment and/or upon termination. Potential civil and criminal liability may result from such conduct.

Posters, calendars, personal affects, etc. are not allowed to be taped, or tacked, to shared areas such as filing cabinets, corridors, walls, or doors. In addition, the placing of items outside of a work station panel is prohibited. If an employee has any items that need to be mounted on a wall within his or her workstation or office, he or she should request assistance from the Facilities Department. CalOptima reserves the right to inspect all CalOptima property to ensure compliance with its policies, rules, and regulations, without notice to the employee and at any time, not necessarily in the employee's presence.

Employees are asked to minimize personal phone calls and messages from personal callers to avoid interruption of work. CalOptima understands that, from time-to-time, personal, or family calls or messages, are necessary; however, employees are expected to use good judgment and, whenever possible, to limit these calls to meal and break times. CalOptima reserves the right to monitor voice mail messages and email messages to ensure compliance with this rule, without notice to the employee and at any time, not necessarily in the employee's presence. Employees should be aware that as a public agency, all documents, including email messages and instant messages, are public records and may be subject to disclosure. Employees should not have any expectation of privacy concerning email messages sent and received from CalOptima email or instant messages sent and received through CalOptima's network.

Communication through CalOptima systems, including, but not limited to, emails, facsimile and telephones, may be monitored or recorded, and employees should not have an expectation of privacy or confidentiality in communications made through CalOptima-owned equipment.

In the event that a telephone call to a member, provider, third-party or employee, or a virtual online presentation, meeting or educational session is to be recorded by CalOptima, CalOptima employees will be responsible for notifying all parties about the recording. Participants may consent to the recording, explicitly or implicitly by remaining on the call or presentation. To legally record a conversation, all parties must be made aware of the recording and consent, either explicitly or by continuing with the conversation after notice. Otherwise, in California, it is a criminal offense to use any device to record communications, whether they are wire, oral or electronic, without the consent of everyone taking part in the communication.

Prior authorization must be obtained before any CalOptima property may be removed from the premises. For security reasons, employees should not leave personal belongings of value in the workplace or in plain view. Employees are solely responsible for their own personal belongings, and CalOptima shall not be liable for any lost, stolen or misplaced personal belongings. Personal items in and on CalOptima property are subject to reasonable inspection and search.

Terminated employees must remove any personal items at the time they leave CalOptima or make arrangements with Human Resources to remove these items. Personal items left in the workplace are subject to disposal if arrangements are not made at the time of an employee's termination. CalOptima shall not be responsible for any lost, or discarded, personal items left behind. Terminated employees who have CalOptima property at their home must make arrangements with Human Resources to have these items picked up within a week of their termination date.

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# Housekeeping

All employees are expected to keep their work areas clean and organized. The use of personal floor, or desktop heaters, coffee makers, and mini-refrigerators is not permitted in the cubicles.

People using common areas such as lunch rooms, locker rooms, conference rooms, and restrooms are expected to use appropriate and courteous etiquette including keeping the common areas sanitary and in a clean state for the next person to use. Clean shared equipment and touchable surfaces frequently. Employees should clean up immediately after meals and dispose of trash properly. Washing or sanitizing hands before and after using common areas, such as breakrooms, is encouraged. CalOptima encourages good health habits to prevent the spread of germs, colds, the flu, and other illnesses.

# Off-Duty Use of Facilities

Employees are prohibited from remaining on CalOptima premises or making personal use of CalOptima facilities while not on duty without prior permission from the Human Resources Department.

# Cell Phones

**Driving with Cell Phones:**
In the interest of the safety of our employees and other drivers, and in compliance with state laws, CalOptima employees are prohibited from using cell phones without a hands-free device and prohibited from text messaging and/or searching the internet while driving on CalOptima business and/or driving during CalOptima time. If an employee's job requires that he or she keep his or her cell phone turned on while he or she is driving, he or she must use a hands-free device and operate the vehicle safely. Cell phones may not be used under any circumstances or in any manner that would distract an employee from the duty to drive in a safe and non-negligent manner.

**Cell Phone Etiquette:**
We ask that employees are considerate of others when using a cell phone during work hours and while on duty. Appropriate phone etiquette includes putting phones on silent, or vibrate, mode to minimize disruptions, and minimizing text messaging and internet surfing during meetings. Employees should refrain from excessive use of personal hand-held devices during work hours and while on duty for non-job-related duties. Employees are asked to minimize personal cell phone calls and text messages or personal emails unrelated to CalOptima business on hand-held devices to avoid interruption of work. Employees are asked to refrain from using cell phones in restrooms. Employees are expected to use good judgment and, whenever possible, to limit these personal cell phone calls or use of hand-held devices to meal and break times.

# Restrictions on Smoking and Unregulated Nicotine Products

As a public agency providing access to quality health care services, CalOptima endeavors to maintain a safe and healthful environment for its employees, members, and visitors to CalOptima property. In keeping with this philosophy, it is important that the workplace and office environment reflect CalOptima's concern for good health. Therefore, smoking, inclusive of electronic smoking devices, and the use of unregulated nicotine products is strictly prohibited inside the building and is allowed only in designated outside smoking areas at least twenty-five (25) feet away from any CalOptima owned, or leased, building. Employees who wish to smoke, inclusive of electronic smoking devices, or use unregulated nicotine products, must limit their smoking or use of unregulated nicotine products to break and meal periods in areas outside of work premises and only in designated smoking areas.

See CalOptima Policy GA.8048: Restrictions on Smoking and Unregulated Nicotine Products

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# Computer, Email, and Internet Usage

CalOptima recognizes that use of the Internet has many benefits for CalOptima and its employees. The Internet and email make communication more efficient and effective. Therefore, employees are encouraged to use and access the Internet appropriately. Unacceptable use of the Internet and email can place CalOptima and others at risk. As a public agency, we must be mindful that our written communications, stored data, and internet searches could constitute a public record. Therefore, all communications, including emails, and internet usage should be business appropriate.

The following guidelines have been established for using the Internet and email in an appropriate, ethical, and professional manner:

- CalOptima's Internet and email access may not be used for transmitting, retrieving, or storing of any communications of a defamatory, discriminatory, or harassing nature, or materials that are obscene, sexually suggestive, or explicit.
- No messages with derogatory, or inflammatory, remarks about an individual's race, age, disability, religion, national origin, physical attributes, or sexual preference shall be transmitted. Harassment and discrimination of any kind or form is strictly prohibited.
- Disparaging, abusive, profane, discriminatory, or offensive language and any illegal activities are forbidden. The posting, uploading, or downloading of pornographic or vulgar messages, photos, images, sound files, text files, video files, newsletters, or related materials is strictly prohibited.
- Each employee is responsible for the content of all text, audio, or images that he or she places or sends over CalOptima's Internet and email system. No email, or other electronic communications, may be sent that hides the identity of the sender or represents the sender as someone else.
- All CalOptima business should be conducted using CalOptima equipment and systems. CalOptima employees do not have access to personal email accounts over the internet. Access from work computers to consumer email services such as Google Gmail, Yahoo! Mail, AOL, Hotmail, live.com, EarthLink, university email systems, cable provider email systems, etc. is not available. Emails that are received from these services from members, providers, or others are permitted
- Users shall have no expectation or assumption of confidentiality, or privacy, of any kind related to the use of emails and the Internet. CalOptima has the right, with or without cause or notice, to access, examine, monitor, and regulate all electronic communications, including email messages, directories and files, as well as Internet usage. Also, the Internet is not secure, so employees should not assume that others cannot read, or possibly alter messages.
- Internal and external email messages are considered business records and may be subject to discovery in the event of litigation, or disclosure, in the event of a public records request. Be aware of this possibility when sending email within and outside CalOptima.
- Users shall ensure the security of Protected Health Information (PHI) in accordance with CalOptima's HIPAA policies. Sensitive data (PHI) should not be stored on nor sent to through any employee's personal consumer email services. Examples include Yahoo!, live.com, Gmail, Hotmail, AOL, or any other non-CalOptima email system.
- Users shall be responsible for using the Internet, email, InfoNet, and internal office communicator in an appropriate manner. CalOptima shall block access to categories of websites deemed inappropriate (illegal, pornographic, etc.) or unnecessary (entertainment, games, etc.).

All CalOptima-supplied technology, including computer systems and CalOptima-related work records, belong to CalOptima and not the employee. CalOptima may routinely monitor usage patterns for its email and Internet communications. Since all the computer systems and software, as well as the email and Internet connection, are CalOptima owned, all CalOptima policies are in effect at all times during usage. Any employee who abuses the privilege of access to email and/or the Internet may be denied access to the Internet and, if appropriate, be subject to corrective action up to and including termination.

CalOptima may periodically need to assign and/or change passwords and personal codes for voice mail, email, or

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1 computer login. CalOptima reserves the right to keep a record of all passwords and codes used for CalOptima
2 business and/or may be able to override any such password system.
3
4 CalOptima has separate agreements with wireless providers. As a result, CalOptima employees may be eligible
5 for discounts with these providers. Please check with Human Resources for more information.
6
7 See CalOptima Policies GA.5005a: Use of Technology Resources, GA.5005b: E-mail and Internet Use and
8 HH.3014Δ: Use of Electronic Mail with Protected Health Information
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## 11 Solicitation, Distribution, and Bulletin Boards

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13 CalOptima is an employer that values families and nonprofit organizations, and we want to support our employees
14 with their fundraising activities. Employees should reserve fundraising activities for non-work time (breaks and
15 lunch, or after hours) and in non-work areas (break rooms). Solicitations should be discrete, courteous, and
16 carried out in a manner that does not interfere with CalOptima's operations. Please make sure that any solicitation
17 involves requests that are professional and in good taste.
18
19 An employee may distribute, or circulate, non-CalOptima written materials to other employees only during non-
20 working time and only in non-work areas. If an employee is unclear whether an area is a work, or non-work, area,
21 he or she should consult his or her immediate supervisor or the Human Resources Department for clarification.
22
23 Solicitation, or distribution, in any way connected with the sale of any goods or services for profit is strictly
24 prohibited anywhere on CalOptima property at any time, unless otherwise approved by management. Similarly,
25 solicitation, or distribution, of literature for any purpose by non-employees is strictly prohibited on CalOptima's
26 property at any time.
27
28 CalOptima has a bulletin board located on each floor for the purpose of communicating with its employees.
29 Postings on these boards are limited to CalOptima related material including statutory and legal notices, safety
30 and work-related rules, CalOptima policies, memos of general interest relating to CalOptima and other items. All
31 postings require the prior approval of the Human Resources Director, or designee.
32
33 Unauthorized posting of literature on CalOptima property (including bulletin boards, walls, and the outside of
34 cubicles) is strictly prohibited.
35
36

## 37 Photo-Identification Badges

38
39 Employees of CalOptima are required to wear their photo-identification badges while at CalOptima and, when
40 appropriate, while conducting CalOptima business. Photo identification badges must be visible at all times while
41 working on site. In addition, an employee's photo-identification badge also serves as a key to allow an employee
42 access to the entrance of the building, his or her department, restrooms, break/lunch room, and other permitted
43 areas within the building.
44
45 Photo-identification badges and/or key cards are not transferable to other CalOptima employees, vendors, or
46 family members.
47
48 The employee's photo-identification badge is the property of CalOptima and must be returned when employment
49 is terminated for any reason.
50
51 We also encourage employees to be aware of people in our work areas to make sure they are wearing a badge and
52 are either CalOptima employees or escorted by CalOptima employees. If an employee notices someone who is not
53 wearing a badge, they are expected to report them to the Facilities Department.
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25 # Wages and Work Schedules
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# Work Schedules

CalOptima's normal hours of operation are between the hours of 8 a.m. and 5 p.m., Monday through Friday, and our reception area is open during these hours. You and your supervisor will work out your individual work schedule, meal period, and break times. All employees are expected to be at their desks, or work stations, at the start of their scheduled shifts, ready to work. CalOptima reserves the right to modify employees' starting and ending times and the number of hours worked.

# Timekeeping Requirements

Efficient business operations depend on the reliability of all employees. CalOptima employees are required to follow established guidelines for recording their hours worked.

All hourly (non-exempt) employees are required to accurately record time in CalOptima's timekeeping system. Hourly employees must record their own time by clocking in at the start of the scheduled shift and clocking out at the end of their scheduled shift, as well as clocking out at the beginning of their scheduled meal break and clocking in at the end of their scheduled meal break on a daily basis. Except for scheduled break times, hourly employees also must record their time away from CalOptima premises whenever they leave the building for any reason other than CalOptima business. Hourly (non-exempt) employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks.

Clocking in/out for another employee or having another employee clock in/out for the employee constitutes falsification of timekeeping records and is grounds for immediate termination for one (1) or both employees, depending on the circumstances. Hourly employees who consistently fail to accurately and timely clock in/out may receive corrective action, up to and including termination of employment.

It is the responsibility of each employee to verify and approve their time worked as recorded in CalOptima's timekeeping system. Any errors on an employee's time record should be reported immediately to his or her immediate supervisor. By submitting the time sheet each payroll cycle, the employee is representing that the time worked accurately reflects any and all time the employee worked during that pay period.

Supervisors will determine and notify employees of their regular work schedule/shift. Due to possible changes in work force and CalOptima's needs, CalOptima retains the right to change an employee's work schedule, or the number of hours worked in a day, subject to all applicable wage and hour laws.

When business requirements or other needs cannot be met during regular working hours, employees may be scheduled to work overtime hours. Hourly (non-exempt) employees will receive overtime pay for any overtime hours worked. Hourly (non-exempt) employees may NOT work overtime without prior authorization from their immediate supervisor. Hourly employees are not permitted to start work early, finish work late, work during meal periods, take work home, work on weekends, or perform any other unauthorized extra and/or overtime work without prior authorization from their immediate supervisor. Hourly employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks.

Salaried (exempt) employees are not required to complete timecards and are not eligible for overtime. However, as a public agency employer, CalOptima has expectations of employees that are established pursuant to principles of public accountability. Exempt employees are expected to work a regular work schedule based on CalOptima's core business hours and should notify their supervisors in advance of any deviations from their normal work schedule and accurately record any exceptions to their regular work schedule including, but not limited to, hours used for PTO, jury duty, bereavement leave, etc.

CalOptima looks to salaried employees to demonstrate the level of commitment and conscientiousness that is appropriate to their status. Salaried employees work a minimum of eighty (80) hours per pay period (for full-time employees) and may need to work additional hours to complete projects and tasks. Salaried employees are not

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eligible for overtime payment but may be asked to work additional hours when business needs require. CalOptima does not provide "comp time" to non-salary or salaried employees for hours worked beyond the forty (40)-hour workweek.

Subject to the supervisor's prior approval, a salaried employee may request a partial day absence (for example, two (2) hours for a doctor's appointment). When an occasional, short-term scheduled absence for a partial day occurs the salaried employee may make up time away from work within the same pay period or use accrued PTO if the employee does not otherwise make up the time off within the same pay period. If the employee has exhausted all his or her accrued PTO and does not otherwise make up the time off within the same pay period, the partial day absence will be unpaid time off.

Directors, managers, and supervisors are accountable to ensure that attendance and timekeeping policies and procedures are adhered to, to monitor their employees' attendance on a daily basis, reasonably verify the accuracy of the timekeeping entries for non-exempt employees, and address attendance issues in a timely and consistent manner.

See CalOptima Policy GA.8059: Attendance and Timekeeping

## Workweek and Workday

The workweek on which weekly overtime calculations will be based begins each Sunday at midnight (12:01 a.m.) and ends the following Sunday at midnight. The workweek will differ for employees working an alternative schedule such as 9/80 (see section regarding Alternative Work Schedules).

## Payment and Wages

Normal paydays are every other Friday. Please consult CalOptima's pay schedule available through the Payroll Department.

Each paycheck will include base earnings for all reported hours performed through the end of the payroll period. The payroll period ends the Sunday prior to pay day at 12 a.m. An itemized statement of wages is available each payday online in Dayforce. If the payday (Friday) falls on a holiday, payroll checks will be available on Thursday.

## Payment on Resignation or Termination

According to California Labor Code Section 220 (b), as a public agency, CalOptima is not required to pay wages immediately upon termination. If an employee resigns or is terminated, his or her final paycheck will be available on CalOptima's next regularly scheduled payday. The employee's final paycheck will include payment for all wages due and not previously paid and for accrued but unused PTO/Flexible Holiday, minus authorized deductions.

## Overtime

**Hourly (Non-Exempt) Employees**
Periodically, a need for overtime arises, either before or after the regular workday or on weekends. As a public agency, we follow federal wage and hour laws. Overtime will be provided for all hours worked in excess of forty (40) hours in any one (1)workweek at the rate of 1½ times the non-exempt employee's regular rate of pay. Overtime must be approved in advance by management.

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**Salaried (Exempt) Employees**
Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

## Meal and Rest Periods

CalOptima recognizes how important it is to have a break during the work day. As a result, CalOptima encourages employees who work for a period of more than five (5) hours to take an unpaid meal period of at least thirty (30) minutes. CalOptima also recommends a paid rest period of no more than fifteen (15) minutes to be taken approximately halfway through any work period of three and one-half (3.5) hours, or more. For example, employees should receive one (1) fifteen (15)-minute rest period in the first half of an eight (8)-hour shift, and one (1) fifteen (15)-minute rest period in the second half of an eight (8)-hour shift. Employees may not combine their breaks and lunch to alter their normal work hours.

## Lactation

Employees may take a reasonable amount of break time, subject to certain limitations, in order to express milk for the employee's child. The break shall run concurrently with rest breaks or lunch periods already provided to the employee but shall otherwise be unpaid.

## Holiday Pay

Employees are paid their regular straight-time wages for CalOptima paid holidays as set forth in the Holidays section under Benefits in this handbook.

## Make Up Time

CalOptima allows the use of makeup time when employees need time off to tend to personal obligations. For example, an employee might request makeup time in advance for the following situations:

- An employee needs to leave one (1) hour early for a doctor's appointment on Monday and asks to make up that time on Tuesday by working an hour later.
- An employee on a 9/80 workweek will receive eight (8) hours of holiday pay on a nine (9) hour day and he or she asks in advance to make up the additional hour rather than take it from his or her PTO accruals.

Make up time worked will not be paid at an overtime rate and the workweek in which the makeup time occurs cannot exceed forty (40) hours. Employees may take time off and then make up the time later in the same workweek or may work extra hours earlier in the workweek to make up for time that will be taken off later in the workweek.

Non-exempt employees should submit make up time requests in advance to their supervisor. Requests will be considered for approval based on the legitimate business needs of the department at the time the request is submitted. A separate written request is required for each occasion the employee requests make up time.

An employee's use of make-up time is completely voluntary. CalOptima does not encourage, discourage, or solicit the use of make-up time.

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# Supplemental Compensation

In certain instances, CalOptima offers supplemental compensation, in addition to an employee's regular base pay, to compensate for business needs. Supplemental compensation includes, but is not limited to, compensation for:

- **Overtime Pay:** Non-exempt employees will be paid overtime pay at a rate of one and one-half (1.5) times the employee's regular rate of pay for all hours worked in excess of forty (40) hours in any one (1) workweek. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.
- **Night Shift Pay:** A non-exempt employee who works an assigned night shift shall, in addition to his or her regular base pay, be paid a supplemental night shift pay for each hour actually worked on the assigned night shift.
- **Bilingual Pay:** A supplemental bilingual pay may be paid to qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages and bilingual usage for members is required or preferred in the job description.
- **Call Back Pay:** In certain departments, non-exempt employees are eligible for call back pay should they be asked to physically return to work within one (1) hour by their supervisor.
- **On Call Pay:** On occasion, employees may be asked to be on call. On call pay is compensation provided to employees who must remain accessible after hours and/or on the weekends via pager, or mobile phone, and be available to work via phone, fix problems or report to work, if necessary.
- **Active Certified Case Manager (CCM) Pay:** Supplemental pay may be paid to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties.
- **Sales Incentive Program:** Eligible employees in the Member Outreach & Education Department may be eligible to receive a sales incentive that corresponds to the number of eligible members the employee enrolls in the OneCare and OneCare Connect Programs each month.
- **Translation Pay:** The Cultural and Linguistic Services Program may compensate CalOptima exempt employees outside of their department for translation work.
- **Executive Incentive Program:** The Chief Executive Officer may recognize executive staff, including interim appointments, using incentive compensation as described in CalOptima Policy GA.8042: Supplemental Compensation. For executive staff who achieve superior performance, the executive incentive compensation is considered bonus pay pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as special compensation for classic Members.

See CalOptima Policy GA.8042: Supplemental Compensation

# Severance Pay

The Chief Executive Officer (CEO), in his sole and complete discretion, may authorize severance pay upon an employee's separation from service when it is deemed appropriate due to special circumstances; e.g., separations due to changing needs of CalOptima, a reorganization of functions or staffing, lack of work, changes in the technology or methods used for a specific position, and/or resolution of a potential dispute.

See CalOptima Policy GA.8047: Reduction in Force

# Merit Pay

The annual performance review period established by the Chief Executive Officer is typically April 1–March 31, with the annual salary review date occurring in July. In the event a performance review date is delayed for an employee and a positive performance review is given for the covered period that results in a recommended salary increase, CalOptima may make salary adjustments retroactive to the original performance review date with the

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approval of the Human Resources Department and subject to the guidelines set by the Human Resources Department.

## Unemployment Compensation

CalOptima contributes to the California Unemployment Insurance Fund on behalf of the employee. This insurance provides income in the event an employee loses his or her job through no fault of his or her own. Eligibility for Unemployment Insurance is determined solely by the Employment Development Department (EDD) of the State of California. Qualified employees should register at their nearest Employment Development Department in order to receive benefits. The amount of unemployment insurance payments varies according to income level.

## Short-Term Disability

CalOptima does not participate in the State of California Disability Insurance Plan. Instead, CalOptima operates under an approved private plan of disability insurance. This plan provides for loss of income resulting from non-work-related illness or injury, paying seventy percent (70%) of regular income for up to a maximum of twelve (12) weeks for all benefit-eligible employees. There is a fourteen (14) calendar day waiting/elimination period on illness-related and accident-related disabilities. CalOptima provides this benefit free of charge to employees.

## Long-Term Disability

CalOptima provides a rich long-term disability program. Regular full-time and part-time employees are eligible to receive long-term disability coverage, following a ninety (90) calendar day waiting period, during which short-term disability is provided the first month following ninety (90) calendar days of employment. All benefit eligible employees are automatically enrolled into this benefit.

## Alternative Work Schedules (9/80)

CalOptima has established an alternative workweek schedule as another way for employees to manage work/life balance and provide CalOptima the opportunity to maintain productivity through different work schedules. Employees will be considered for alternative workweek scheduling on a case-by-case basis. The department director/manager is responsible for identifying if an alternative workweek is practical and effective for their department by evaluating both the productivity and quality impacts of the schedule to the department and the needs of the department to ensure service goals can be consistently achieved.

The 9/80 alternate work schedule consists of eight (8) business days of nine (9) work hours per day and one (1) business day of eight (8) work hours for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8)-hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) workweek.

Not every position at CalOptima is eligible for alternative work scheduling. Full-time employees who are interested should discuss this with their supervisor. Employees must receive approval from their supervisor and Human Resources to participate in the 9/80 work schedule. Employees not meeting job standards or expectations and/or who are on a performance improvement plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources before denying the

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option. Transitioning to the new workweek can result in either fewer, or more, than eighty (80) hours in a pay period. Human Resources will work with management to minimize incurring overtime during the transitional period.

Paid time off (PTO) accrual will remain the same for participating employees. When an employee takes a day off under the PTO policy, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9)-hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9)-hour workday, the employee has the option of using one (1) hour of accrued PTO or working one (1) hour of make-up time during the same workweek. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same workweek.

Employees are expected to continue to provide the same level of excellent service expected of them. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 work schedule based on business needs or performance issues. As a condition of participating in the 9/80 work schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager.

The 9/80 alternate work schedule is an optional program. CalOptima reserves the right to discontinue the entire program, or an individual employee's participation in the program at any time, for any reason, at management's discretion. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

See CalOptima Policy GA.8020: 9/80 Work Schedule

## Telework

CalOptima is committed to providing a work environment that assists employees to achieve a proper balance between their work, home and family obligations. In some cases, this balance can best be achieved by allowing employees to perform their work from their homes when they can do so without compromising their work quality, efficiency, or productivity. Telework is not a universal employee benefit, or entitlement, but an alternative method of meeting the work needs of the organization through a flexible work structure. Telework is a voluntary workplace arrangement in which an eligible employee works his or her entire work schedule away from the central worksite at a remote work location.

An employee's participation in the Telework Program must be pre-approved by an employee's supervisor, director, Environmental Health & Safety Manager, and Human Resources. A Telework Agreement, other mandatory pre-deployment documentation and a telework orientation must be completed before an employee may begin working from their residence.

To participate in the telework program, an employee must meet eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from their home and their ability to meet performance expectations in a remote work environment. A teleworker must also maintain a suitable and secure designated workspace inside their residence that is clean, safe, and free from distractions. CalOptima's policies, rules and practices and the employee's conditions of employment are all applicable to a teleworker.

CalOptima retains the right, in its sole discretion, to designate positions that are appropriate for teleworking and approve employees for teleworking. Teleworking does not change the conditions of employment or required compliance with all CalOptima policies and procedures. CalOptima reserves the right to change, or terminate, the Telework Agreement at any time, with or without cause, or advance notice. An employee's ability to work under a Telework Agreement rests in the sole discretion of CalOptima and requires that the employee be and remain in good standing. Any employee placed on a performance improvement plan or issued any other corrective action shall be removed from and is not eligible for teleworking.  Teleworking is a voluntary alternative work

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arrangement and may not be appropriate for all employees and/or all positions. Any employee wishing to telework must first discuss this option with his or her supervisor and Human Resources.

When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a remote work location on an occasional basis. Occasional is defined as rare, infrequent, and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a remote work location routinely. This is not considered or counted as a telework position.

Employees who occasionally work from a remote work location must abide by the same requirements as employees who telework. An employee who occasionally works off-site must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department.

See CalOptima Policy GA.8044: Telework Program

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17 # Leaves of Absence
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# Leaves of Absence Overview

CalOptima will grant a leave of absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures and all applicable laws. An employee's manager may approve up to five (5) business days of excused absences for an illness, or pre-planned surgery; however, absences of more than five (5) scheduled work days for illnesses, or pre-planned surgery must be submitted to and approved by HR for LOA consideration. Use of PTO time for pre-planned vacations does not require HR approval.

If the LOA is granted, the start date of the LOA will be the first day of the requested, substantiated, and approved LOA. Requests for a LOA must be made through the Human Resources Department. To be eligible, employees are required to submit all applicable forms, including, but not limited to, sufficient medical documentation, to the Human Resources Department in a timely manner, unless in special circumstances where timely submission may not be feasible.

Employees who satisfy the eligibility requirements set out in CalOptima's respective policies and applicable laws may be granted one (1) or more of the following types of LOAs. These leaves include:

a. Pregnancy Disability Leave
b. Family Medical Leave
c. California Family Rights Leave
d. Military Family Leave
e. Military Service Leave
f. Military Spouse Leave
g. Workers' Compensation Leave
h. Jury or Witness Duty Leave
i. Parental School Attendance
j. Voting Leave
k. Victims of Domestic Violence, Sexual Assault, or Stalking Leave
l. Victims of Crime Leave
m. Volunteer Civil Service Leave
n. Civil Air Patrol Leave
o. Bereavement Leave
p. Personal Leave

Employees taking any LOA must use their full balance of PTO before moving to unpaid leave, unless deemed otherwise by law (e.g., Pregnancy Disability Leave, etc.).

Employees may not engage in outside work for other employers while on an approved leave of absence from CalOptima, other than military service. CalOptima Policy GA.8037: Leave of Absence, defines further compensation requirements applying to employees taking LOA.

Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, or Automobile Allowance during his or her LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA, but shall not be eligible if the LOA is unpaid. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

See CalOptima Policies; GA.8037: Leave of Absence, GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CRFA) Leaves of Absence, GA.8041: Workers' Compensation Leave of Absence

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# Types of Leaves:

## Pregnancy Disability Leave

Pursuant to the California Fair Employment and Housing Act (FEHA), Pregnancy Disability Leave (PDL) is available to eligible employees who are temporarily disabled by pregnancy, childbirth, or a related medical condition. PDL is available for up to four (4) months, including intermittent periods.

An employee may request to use accumulated PTO during the PDL and is eligible for disability benefits. If PDL is foreseeable, and when practicable, a thirty (30) calendar day advance notice is required. Health benefits and other insurances will continue during the PDL period, and the employee is required to pay her portion of coverage at the active employee rate, either by the usual payroll deduction if the employee is still receiving a paycheck, or by making other payment arrangements with the CalOptima Human Resources Department.

See CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence

## Family Medical Leave Act and California Family Rights Act Leave

State and federal family and medical leave laws provide up to twelve (12) workweeks of unpaid family/medical leave within a twelve (12)-month period. Full-time and part-time employees must meet the following conditions:

- The employee must have a total of at least twelve (12) months of service at CalOptima.
- The employee must have worked at least one thousand two hundred fifty (1,250) hours during the previous twelve (12)-month period before the need for leave.

An eligible employee may take continuous, intermittent or reduced schedule, when medically necessary, unpaid leave of absence under the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) for the following reasons:

- To care for the employee's newborn child, or placement of a child with an employee for adoption, or foster care.
- To care for the employee's spouse, domestic partner, child, parent, grandparent, grandchild, or sibling who has a serious health condition.
- For the employee's own serious health condition that makes the employee unable to work at all, or unable to perform the functions of his or her job (While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.).
- To care for a spouse, child, or parent who is a covered military service member on active duty, or has been notified of an impending call, or order, to active duty.
- To care for a covered military service member with a qualifying serious injury or illness if the employee is the spouse, child, parent, or next of kin of the military service member. Under FMLA, an eligible employee may take up to twenty-six (26) weeks, during a single twelve (12)-month period, of unpaid leave to care for a covered service member with a qualifying serious injury, or illness.

An employee is required to use accumulated PTO during FMLA and/or CFRA LOA, unless deemed otherwise by law and may be eligible for disability benefits if the LOA is due to his or her own illness. If FMLA/CFRA is foreseeable, and when practicable, a thirty (30) calendar day advance notice is required. Health benefits and other insurances will continue during the FMLA/CFRA leave period and the employee is required to pay his or her portion of coverage at the active employee rate.

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1 See CalOptima Policies; GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act
2 (CFRA) Leaves of Absence
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## 5 Coordination of PDL with FMLA and/or CFRA

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7 If an employee takes PDL and is eligible for a LOA under FMLA and/or CFRA, CalOptima will continue to make
8 payments towards group health insurance coverage during the period of the PDL, FMLA and/or CFRA, subject to
9 the employee's timely payment of his or her portion of coverage at the active employee rate. For any leave taken
10 under PDL, FMLA runs concurrently with PDL, and may run concurrently with CFRA if less than twelve (12)
11 weeks of PDL are taken.
12
13 If an employee is ineligible under FMLA and CFRA for a LOA, CalOptima will continue to pay the employer's
14 portion of payments to group health insurance coverage during the period of the PDL, subject to the employee's
15 timely payment of his or her portion of coverage at the active employee rate. In some instances, CalOptima may
16 recover premiums it paid to maintain health coverage for an employee if the employee fails to return to work
17 following PDL.
18
19 If an employee exhausts her PDL and any other protected leave, and the employee is granted a Personal LOA,
20 CalOptima will not pay for group health insurance premiums during any remaining portion of a Personal LOA.
21 The employee is fully responsible for timely electing COBRA health coverage and paying for the full cost of
22 health insurance premiums during the remaining portion of the Personal LOA. Failure to timely make the
23 COBRA election and/or failure to pay premiums in a timely manner will result in immediate termination of
24 coverage through the remainder of the Personal LOA.
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26 See CalOptima Policies; GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act
27 (CFRA) Leaves of Absence
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## 30 Military Service Leave

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32 CalOptima employees who are members of "uniformed services" (e.g., Army, Navy, Air Force, Marine Corps,
33 Coast Guard, and the reserves of each of those branches: Army National Guard, Air National Guard, or similar
34 branches) will be granted, upon request, a cumulative of five years of leave of absence (with certain exceptions)
35 without pay for both inactive and active duty (e.g., military training, drills, encampments, cruises, special
36 exercises, or similar activities). All regular full-time and part-time employees are eligible for Military Service
37 Leave.
38
39 In certain circumstances employees on a Military Service Leave may be entitled to up to thirty (30) calendar days'
40 salary and benefits continuation in any one (1) fiscal year.
41
42 Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty,
43 or active training duty, with the U.S. Armed Forces, or National Guard, as a result of the National Emergency
44 arising from the War on Terror, may receive supplemental compensation and continuation of benefits during the
45 Military Service Leave.
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47 Employees will be required to complete a Leave of Absence Request form and provide a copy of all military
48 orders to the Human Resources Department.
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50 An employee who returns from a Military Service Leave will be reinstated to the same position, or a position of
51 like seniority, status, and pay in accordance with the Uniformed Services Employment and Reemployment Rights
52 Act of 1994 (USERRA) and Section 395.1 of the California Military and Veteran's Code.
53
54 See CalOptima Policy GA.8037: Leave of Absence

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## Military Spouse Leave

In addition, employees who are regularly scheduled to work an average of twenty (20), or more, hours per week and who are spouses of qualified military service members, are eligible to take up to ten (10) scheduled work days of unpaid leave when their spouses are on leave from active duty in the U.S. armed forces, reserves, or National Guard. Employees may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid. Employees must give a minimum of two (2) business days' notice of their need for leave and provide appropriate written documentation to the Human Resources Department.

See CalOptima Policy GA.8037: Leave of Absence

## Workers' Compensation Leave

In accordance with state law, CalOptima provides Worker's Compensation insurance coverage for employees in case of a work-related injury or illness. Employees are required to report all on-the-job injuries to their supervisor and the Human Resources (HR) Department immediately, regardless of how minor the injury may be. Employees who sustain a work-related injury or illness may be granted a leave of absence as required by law. CalOptima may grant a Leave of Absence (LOA) consistent with CalOptima's various leave policies to any employee who is unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act.

While employees are on a leave of absence, they should stay in contact with CalOptima's Human Resources Department and their supervisors regarding their expected return to work. CalOptima may engage in an interactive process (where applicable) with the employee to determine if there are any reasonable accommodations available that may be effective in allowing the employee to return to work or whether extended time off will be a reasonable accommodation or create an undue hardship on CalOptima. Subject to any limitations permitted by law, including, but not limited to, business necessity or undue hardship, time off for work-related injury or illness may be extended to the employee for the duration of the injury or illness, until the employee has recovered sufficiently to perform the duties of his or her job or a modified light duty position if one is offered by CalOptima, or the employee's condition is declared permanent and stationary and he or she is unable to perform the essential functions of his or her job, with or without reasonable accommodation.

See CalOptima Policy GA.8041: Workers' Compensation Leave of Absence

## Jury or Witness Duty Leave

CalOptima will grant a LOA with regular pay for those hours that coincide with the employee's regularly-scheduled working hours for the purpose of jury service, appearance as a witness in court (other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee.) Employees are required to provide reasonable advance notice of any need for such leave.

On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members. Employees seeking an official Jury Duty Leave should submit to their immediate supervisor a Leave of Absence Request Form accompanied by a copy of the official order not less than ten (10) calendar days prior to the beginning of the date

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of the leave. The employee must submit to the Payroll Department the payment received for the jury service, excluding payments for mileage.

See CalOptima Policy GA.8037: Leave of Absence

## Parental School Attendance

Pursuant to Labor Code Section 230.8, employees can take time off up to eight (8) hours in one (1) month, or forty (40) hours each year to participate in school activities of their children, subject to limitations under applicable laws. Pursuant to Labor Code Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code Section 48900.1 (suspension of pupil), subject to conditions. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

## Bereavement Leave

With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step, or foster child; biological, adopted, step, or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documents for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO or unpaid time off. If the employee plans to take additional time off exceeding five (5) scheduled work days, the employee must submit an LOA request form to HR and request a Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence.

## Time Off for Voting

CalOptima encourages employees to fulfill their civic responsibilities by voting. Employees who are unable to vote before or after work should request time off to vote from their supervisor at least two (2) working days prior to election day so that the necessary time off can be scheduled at the beginning or end of the work day, whichever provides the least disruption to the normal work schedule.

See California Elections Code, Section 14000

## Victims of Crime or Abuse

Subject to the requirements under Labor Code sections 230 and 230.1, an employee who is a victim of a crime or abuse may, with reasonable advance notice, unless the advance notice is not feasible, request an LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of a crime. Employees may elect to use accrued PTO, if available, when an LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a twelve (12)-month period. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid.

See CalOptima Policy GA.8037: Leave of Absence

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## Victims of Crime Leave

An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off to attend judicial proceedings related to that crime, subject to the procedural conditions imposed pursuant to Labor Code Section 230.2.

The absence from work must be in order to attend judicial proceedings related to a crime. To the extent feasible, before an employee is absent from work for such a reason, the employee much provides documentation of the scheduled proceeding. Such notice is typically given to the victim of the crime by a court, or government agency, setting the hearing, an attorney related to the case, or victim/witness office. Any absence from work to attend judicial proceedings will be unpaid unless employee chooses to use PTO.

See CalOptima Policy GA.8037: Leave of Absence

## Volunteer Civil Service Leave

A Civil Service LOA may be granted for employees who are required to perform emergency duty (reserve peace officers, volunteer firefighter, and emergency rescue personnel). There are no limitations to the amount of time an employee can use for volunteer civil service leave.

An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA not to exceed an aggregate of fourteen (14) scheduled work days per calendar year, for the purpose of fire, law enforcement, or emergency rescue training.

Any Volunteer Civil Service Leave can be taken unpaid unless employee chooses to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the required leave period and the time covered by PTO will still count as part of this leave.

Certification from emergency personnel office, or civil air authority, will be required to verify the employee's eligibility for leave requested.

See CalOptima Policy GA.8037: Leave of Absence

## Civil Air Patrol Leave

Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled work days per calendar year (three (3) days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty.

See CalOptima Policy GA.8037: Leave of Absence

## Extended Disability Leave

Reasonable accommodations for a leave of absence may be granted for a recognized disability, including pregnancy disability and other serious medical conditions that prevent the employee from working, unless such extended leave causes CalOptima undue hardship and/or is indefinite in duration. Human Resources will engage in the "interactive process" with the employee and his or her manager to help determine whether a reasonable accommodation is available in order to grant such leave request.

Employees are required to use PTO during the leave of absence. Group health insurance plans (health, dental, and

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vision) will generally be made available via COBRA after all PTO and protected LOAs have been exhausted.

## Personal Leave

All full-time and part-time employees are eligible to request a Personal Leave of Absence.

A Personal Leave of Absence, without pay, may be granted, in CalOptima's sole discretion, for a reasonable period of time of up to a total of ninety (90) calendar days per twelve (12)-month period. Personal LOAs are entirely dependent on CalOptima's discretion and are only approved when it is determined that granting the LOA will not unduly interfere with CalOptima's operations.

Any accumulated PTO must be used during Personal LOA. Once the employee's PTO has been exhausted, all remaining time off during the approved Personal LOA will be unpaid. The use of such PTO will not adjust the start date of the leave; i.e., time covered by PTO will still count as part of the Personal Leave.

CalOptima does not guarantee that an employee's position will remain vacant while the employee is on an approved Personal LOA. CalOptima may fill the employee's position for business reasons.

If an employee's position is filled while he or she is off on an approved Personal LOA, the employee may, at the conclusion of his or her scheduled leave, apply for any open position for which he or she is qualified at CalOptima. However, if no such position is available, the employee's employment will be terminated.
If the employee fails to return to work at the agreed date, the employee will be treated as having voluntarily resigned his or her employment.

See CalOptima Policy GA.8038: Personal Leave of Absence

## Kin Care

In a calendar year, employees may use up to half of their annual accrued and available PTO for preventative care or care of an existing health condition for the employee or a family member as permitted under Labor Code, Sections 233 (generally known as "Kin Care," but also referred to as "Protected Sick Leave") and 246.5(a). Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code Section 230.8 and 230.7.

For purposes of PTO use, a "child" is defined as a biological, foster, or adopted child; stepchild; or a legal ward. A "child" also may be someone for whom an employee has accepted the duties and responsibilities of raising, even if he or she is not their legal child.

A "parent" is an employee's biological, foster, or adoptive parent; stepparent; or legal guardian.

A "family member" includes a grandparent, grandchild, and sibling.

A "spouse" is an employee's legal spouse according to the laws of California, which do not recognize "common law" spouses (a union that has not been certified by a civil or religious ceremony). All conditions and restrictions placed on an employee's use of PTO apply also to PTO used for care of a child, parent, or spouse.

A "registered domestic partner" is another adult with whom an employee has chosen to share his or her life in an intimate and committed relationship of mutual caring, and with whom they have filed a Declaration of Domestic Partnership with the Secretary of State of California (or another state that allows for such).

A "registered domestic partner's child" is the biological, foster, or adopted child, stepchild, or legal ward of an employee's domestic partner. A "domestic partner's child" also may be someone for whom an employee's

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1 domestic partner has accepted the duties and responsibilities of raising, even if he or she is not the domestic
2 partner’s legal child.
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17 # Safety and Security

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# Safety

CalOptima is committed to providing and maintaining a healthy and safe work environment for all employees. CalOptima believes that the establishment and maintenance of a safe work environment is the shared responsibility of CalOptima and employees at all levels of the organization. CalOptima will attempt to establish a safe environment in compliance with federal, state, and local safety regulations.

Accordingly, CalOptima has instituted an Injury and Illness Prevention Program designed to protect the health and safety of all personnel. A complete copy of the Injury and Illness Prevention Program is kept in the Facilities Department and is available for employees' review.

Every employee is required to know and comply with CalOptima's general safety rules and to follow safe and healthy work practices at all times. Employees may be subject to corrective action, up to and including termination, for engaging in any unsafe or unhealthy work practice or for violation of established safety rules. Each employee is also required to report to his or her supervisor any potential health or safety hazards and all injuries or accidents.

First aid supplies are located in each lunch/copy room. Please report any work-related injuries, or illnesses, immediately to the Environmental Health and Safety Manager and/or Human Resources Department. If an employee witnesses or discovers an accident in which a CalOptima visitor or employee is injured, they are expected to assist the visitor or employee as much as possible, and if the situation is an emergency, to call 911. If the situation is not an emergency, employees should contact the Environmental Health and Safety Manager and/or Human Resources Department for further direction.

See CalOptima Policy GA.8016: Unusual Occurrence

# Security

The security of employees, employee property, and CalOptima property is of vital importance. All employees share responsibility to ensure that proper security is maintained. Any breach of security should be reported promptly to the CalOptima security guard, manager or director of Facilities, and the Human Resources Department. Employees may call upon the CalOptima security guard for assistance by dialing zero (0) and having the receptionist page him/her. For immediate emergencies, dial 911.

The building security guard is stationed in the main lobby of the building. The building security guard hours are twenty-four (24) hours daily, Monday through Friday, and all Friday night until 6 a.m. Saturday morning. If an employee is working late and requires an escort to his or her vehicle, the employee may call the building guard, number located on the InfoNet. If an employee experiences a problem while working on the weekend, or after regular working hours, he or she should call the building after hours emergency number located on the InfoNet.

# Security Cameras

CalOptima takes the safety and security of its employees, members, and CalOptima guests very seriously. Proper video surveillance, where deemed appropriate and necessary, is one of the most effective means of helping to keep CalOptima facilities and properties operating in a safe and secure manner. Therefore, please be aware CalOptima has and monitors video surveillance cameras in common areas throughout its buildings and surrounding property for safety and security reasons. The use of video surveillance is for the purpose of controlling theft, ensuring the safety of CalOptima employees and members, and facilitating the identification of individuals who behave in a disruptive manner, cause damage to CalOptima property, or are otherwise in contravention of CalOptima's policies, procedures, and Code of Conduct.

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# Workplace Violence

CalOptima has a strong commitment to its employees and its members to provide a safe, healthy, and secure work environment. CalOptima has zero tolerance for acts of violence, threats, intimidation, or harassment, whether occurring on CalOptima property, occurring off CalOptima property but while conducting CalOptima business, or occurring off or on CalOptima property but directed towards another or other CalOptima employees. All such acts and threats, even those made in apparent jest, will be taken seriously, and will lead to corrective action, up to and including termination.

It is every employee's responsibility to assist in establishing and maintaining a violence-free and safe work environment. Therefore, employees are expected and encouraged to report any incident which may be threatening to them or their co-workers or any event which they reasonably believe is suspicious activity, threatening, intimidating, or violent. Employees may report an incident to any supervisor, or manager.

A threat includes, but is not limited to, 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, or destroy, property. This includes threats made in jest or as a joke, but which others could perceive as serious.

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. 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.

In emergency situations, employees may report workplace violence to supervisory, or managerial, level employees other than their own supervisors.

See CalOptima Policy GA.8053: Workplace Violence

# Ergonomics

CalOptima is subject to Cal/OSHA ergonomics standards for minimizing workplace repetitive motion injuries. CalOptima will make necessary adjustments to reduce exposure to ergonomic hazards through modifications to equipment and processes and employee training. CalOptima encourages safe and proper work procedures and requires all employees to follow safety instructions and guidelines.

CalOptima believes that reduction of ergonomic risk is instrumental in maintaining an environment of personal safety and well-being and is essential to our business. We provide appropriate resources to create a risk-free environment. For more information, contact the Facilities Department.

# Inspections, Searches, and Monitoring of CalOptima Premises

CalOptima believes that it is important to the efficient and safe conduct of its business to assure access at all times to any property, equipment, records, documents, and/or files, etc. on its premises. CalOptima also believes that maintaining a workplace that is free of drugs, alcohol, firearms, explosives, and other harmful and improper materials is vital to the health and safety of its employees and to the success of the organization. CalOptima also intends to protect against the unauthorized removal of its property from the premises. Accordingly, CalOptima reserves the right to access, inspect, and search CalOptima property and premises at any time.

Prohibited materials, including weapons, explosives, alcohol, and non-prescribed drugs or medications, may not be placed or stored in employees' work spaces or desks. If such prohibited items are found, they will be confiscated by CalOptima and delivered to the proper authorities. In addition, CalOptima reserves the right to inspect personal belongings including, but not limited to, any package, container, bag, briefcase, etc. carried in or

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out of CalOptima by any employee, volunteer, or visitor when deemed appropriate by management and/or CalOptima's security guards. Employees who fail to cooperate in any inspection will be subject to corrective action, up to and including termination.

CalOptima is not responsible for any personal belongings or items placed, or stored, in a work space or desk that is lost, damaged, destroyed, or stolen. Employees have an obligation to cooperate fully with all inspections, investigations, and searches conducted in accordance with this section; failure to do so may result in corrective action, up to and including termination.

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18 # Termination
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# Employment Verification

All requests for employment verification must be directed to the Human Resources Department. No other manager, supervisor, or employee is authorized to release employee information for current, or former, employees. By policy, CalOptima discloses only the dates of employment and the title of the last position held of former employees. If an employee authorizes the disclosure in writing, CalOptima will also inform prospective employers, mortgage companies, etc. of the amount of salary, or wage the employee last earned.

Employees may also participate in The Work Number® service from Equifax to provide automated income and employment verifications. Information about the service can be found on the InfoNet.

# Exit Interviews

At time of separation, employees will be scheduled for an exit interview with the Human Resources Department. This interview allows employees to communicate their views on their work with CalOptima, as well as provide input regarding the requirements, operations, and training needs of their former position. It also provides employees an opportunity to discuss issues concerning benefits and insurance. At the time of the interview, employees must return all CalOptima-furnished property, e.g., uniforms, tools, equipment, I.D. cards, keys (electronic and regular), laptops, cell phones, and CalOptima-related documents. Arrangements for clearing any outstanding debts with CalOptima and for receiving final pay will also be made at this time.

# Termination

We hope employees will enjoy a long and mutually rewarding employment relationship with CalOptima. Sometimes, however, an employee may find it desirable, or necessary, to resign and take employment elsewhere, or CalOptima may need to discharge an employee. In either case, it is important that employees who resign or are terminated are treated with mutual respect to achieve a professional, orderly transition.

An employee is considered to have voluntarily terminated his or her employment with CalOptima when the employee:

- Resigns from CalOptima.
- Fails to return from vacation or from an approved leave of absence at the scheduled date and time.
- Fails to report to work without notice or authorization for three (3) consecutive days.

Employees who elect to resign are asked to provide CalOptima with at least two (2) weeks' notice prior to their final day of work.

From time-to-time, CalOptima may reduce the size of the work force by terminating employees for business, operational, or economic reasons (such as lack of work, restructuring the workforce, reorganizing a department, or job elimination). Should CalOptima consider such terminations necessary, CalOptima will attempt to provide all affected employees with advance notice, when practical. Employees affected by such reductions in force are considered to have been laid-off.

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# Closing

As a CalOptima employee you are encouraged to exemplify the CalOptima mission of providing members with access to quality health care services delivered in a cost-effective and compassionate manner.

More information about CalOptima's policies, standards and practices may be found by consulting individual policies referenced herein found on the InfoNet at Other Resources and Services, Policies and Procedures or by contacting Human Resources at hr@caloptima.org. Employees are responsible for reviewing new and updated policies upon notice of changes.

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# EMPLOYEE RIGHTS

## PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

### ▸ PAID LEAVE ENTITLEMENTS

**Generally, employers covered under the Act must provide employees:**

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

### ▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

### ▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

**1.** is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;

**2.** has been advised by a health care provider to self-quarantine related to COVID-19;

**3.** is experiencing COVID-19 symptoms and is seeking a medical diagnosis;

**4.** is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

**5.** is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or

**6.** is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

### ▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

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For additional information or to file a complaint:
**1-866-487-9243**
TTY: 1-877-889-5627
**dol.gov/agencies/whd**

# CA COVID-19 Supplemental Paid Sick Leave for Non-Food Sector Employees

Hiring entities with 500 or more employees nationwide, and a public or private entity that employs health care providers or emergency responders who excluded such employees from emergency paid sick leave under the federal Families First Coronavirus Response Act are required to provide supplemental paid sick leave to employees for specified reasons related to COVID-19 by September 19, 2020. (See Labor Code section 248.1)

## Qualifying Reasons for Taking COVID-19 Supplemental Paid Sick Leave

*An employee may take leave if the employee is unable to work for any of the following reasons*:

| The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. | The employee is advised by a healthcare provider to self-quarantine or self-isolate due to COVID-19 related concerns. | The employee is prohibited from working by the employer due to health concerns related to the potential transmission of COVID-19. |
|---|---|---|

## Employees Are Covered if They Meet the Following Criteria:

- They work for the following type of employer:
  - An employer with 500 or more employees nationwide OR
  - An entity that employs health care providers or emergency responders and has elected to exclude such employees from emergency paid sick leave under the federal Families First Coronavirus Response Act; AND
- They leave home to perform work.

## Paid Leave Entitlement for Employees

- Amount of Hours of COVID-19 Supplemental Paid Sick Leave:
  - 80 hours for those considered full-time employees, in addition to any other accrued paid sick leave. Full-time firefighters may be entitled to more than 80 hours, but the amount of pay is still capped.
  - For part-time employees with a normal weekly schedule, the number of hours the employee is normally scheduled to work over two weeks.
  - For part-time employees with variable schedules, 14 times the average number of hours worked per day over the past 6 months.
- Rate of Pay for COVID-19 Supplemental Paid Sick Leave:
  - Highest of (1) regular rate of pay for last pay period, (2) State minimum wage, or (3) local minimum wage,
  - **Not to exceed $511 per day and $5,110 in total**

## Enforcement:

- Any employee denied COVID-19 supplemental paid sick leave can file a claim with the Labor Commissioner's Office or a Report of Labor Law Violations. Forms can be found at the Labor Commissioner's Office website, www.dir.ca.gov/dlse/. COVID-19 supplemental paid sick leave for employees must be made available for use immediately upon oral or written requests of the employee.
- **Retaliation or discrimination against an employee requesting or using COVID-19 supplemental paid sick leave is strictly prohibited.** An employee who experiences such retaliation or discrimination can file a claim with the Labor Commissioner's Office.

**This poster must be displayed where employee can easily read it. If employees do not frequent a physical workplace, it may be disseminated to employees electronically.**

For additional information you may contact your employer or the local office of the Labor Commissioner. Locate the office by looking at the list of offices on our website http://www.dir.ca.gov/dlse/DistrictOffices.htm using the alphabetical listing of cities, locations, and communities or by calling (213) 620-6330.

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# 2021 COVID-19 Supplemental Paid Sick Leave

Effective March 29, 2021

Covered Employees in the public or private sectors who work for employers with more than 25 employees are entitled to up to 80 hours of COVID-19 related sick leave from January 1, 2021 through September 30, 2021, immediately upon an oral or written request to their employer. If an employee took leave for the reasons below prior to March 29, 2021, the employee should make an oral or written request to the employer for payment.

**A covered employee may take leave** *if the employee is unable to work or telework for any of the following reasons:*

- Caring for Yourself: The employee is subject to quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer with jurisdiction over the workplace, has been advised by a healthcare provider to quarantine, or is experiencing COVID-19 symptoms and seeking a medical diagnosis.
- Caring for a Family Member: The covered employee is caring for a family member who is subject to a COVID-19 quarantine or isolation period or has been advised by a healthcare provided to quarantine due to COVID-19, or is caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.
- Vaccine-Related: The covered employee is attending a vaccine appointment or cannot work or telework due to vaccine-related symptoms.

**Paid Leave for Covered Employees**

- 80 hours for those considered full-time employees. Full-time firefighters may be entitled to more than 80 hours, caps below apply.
  - For part-time employees with a regular weekly schedule, the number of hours the employee is normally scheduled to work over two weeks.
  - For part-time employees with variable schedules, 14 times the average number of hours worked per day over the past 6 months.
- Rate of Pay for COVID-19 Supplemental Paid Sick Leave: Non-exempt employees must be paid the highest of the following for each hour of leave:
  - Regular rate of pay for the workweek in which leave is taken
  - State minimum wage
  - Local minimum wage
  - Average hourly pay for preceding 90 days (not including overtime pay)
- Exempt employees must be paid the same rate of pay as wages calculated for other paid leave time.

**Not to exceed $511 per day and $5,110 in total for 2021 COVID-19 Supplemental Paid Sick leave.**

**Retaliation or discrimination against a covered employee requesting or using COVID-19 supplemental paid sick leave is strictly prohibited.** A covered employee who experiences such retaliation or discrimination can file a claim with the Labor Commissioner's Office. Locate the office by looking at the list of offices on our website (http://www.dir.ca.gov/dlse/DistrictOffices.htm) using the alphabetical listing of cities, locations, and communities or by calling 1-833-526-4636.

This poster must be displayed where employees can easily read it. If employees do not frequent a physical workplace, it may be disseminated to employees electronically.

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# Financial Summary

March 31, 2021

Board of Directors Meeting
May 6, 2021

Nancy Huang, Chief Financial Officer

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# FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: ($4.2) million, favorable to budget $5.9 million or 58.5%
  - YTD: $21.6 million, favorable to budget $41.8 million or 207.0%
- Enrollment
  - MTD: 826,368 members, favorable to budget 14,449 or 1.8%
  - YTD: 7,202,299 member months, favorable to budget 44,338 or 0.6%
- Revenue
  - MTD: $425.8 million, favorable to budget $155.3 million or 57.4% driven by Medi-Cal (MC) line of business (LOB):
    - $91.7 million of fiscal year (FY) 2019 hospital Directed Payments (DP)
    - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
  - YTD: $3.0 billion, favorable to budget $294.3 million or 10.7% driven by MC LOB:
    - FY 2019 hospital DP and the pharmacy benefit transition postponement
    - Offset by the Bridge Period GME risk corridor and Proposition 56 risk corridor reserve

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# FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $418.9 million, unfavorable to budget $150.4 million or 56.0% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $90.5 million due to FY 2019 DP
    - Unfavorable variance of $57.3 million due to postponement of pharmacy benefit transition
    - Claims utilization increased in current month, but still favorable to budget
  - YTD: $2.9 billion, unfavorable to budget $259.5 million or 9.8% driven by:
    - MC LOB FY 2019 hospital DP and pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic
    - OCC LOB unfavorable to budget $19.2 million or 8.6% due to higher capitation and facilities expense
- Administrative Expenses
  - MTD: $11.8 million, favorable to budget $1.4 million or 10.8%
  - YTD: $100.9 million, favorable to budget $12.8 million or 11.3%
- Net Investment & Other Income
  - MTD: $0.7 million, unfavorable to budget $0.5 million or 40.7%
  - YTD: $5.4 million, unfavorable to budget $5.9 million or 52.3% due to decrease in long-term bond values that are affected by higher interest rates

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# FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 98.4% (98.4% excluding DP), Budget 99.3%
  - YTD: Actual 96.1% (95.9% excluding DP), Budget 97.0%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.8% (3.5% excluding DP), Budget 4.9%
  - YTD: Actual 3.3% (3.6% excluding DP), Budget 4.2%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.90
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $103.8 million

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# Enrollment Summary: March 2021

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | Enrollment (by Aid Category) | Actual | Budget | $ Variance | % Variance |
| 116,343 | 111,092 | 5,251 | 4.7% | SPD | 1,031,924 | 998,409 | 33,515 | 3.4% |
| 515 | 466 | 49 | 10.5% | BCCTP | 4,632 | 4,304 | 328 | 7.6% |
| 295,579 | 318,510 | (22,931) | (7.2%) | TANF Child | 2,630,773 | 2,791,415 | (160,642) | (5.8%) |
| 104,106 | 95,718 | 8,388 | 8.8% | TANF Adult | 895,594 | 839,357 | 56,237 | 6.7% |
| 2,948 | 3,521 | (573) | (16.3%) | LTC | 28,910 | 31,617 | (2,707) | (8.6%) |
| 278,096 | 254,929 | 23,167 | 9.1% | MCE | 2,356,452 | 2,243,008 | 113,444 | 5.1% |
| 11,931 | 11,933 | (2) | (0.0%) | WCM | 104,034 | 107,386 | (3,352) | (3.1%) |
| **809,518** | **796,169** | **13,349** | **1.7%** | **Medi-Cal Total** | **7,052,319** | **7,015,496** | **36,823** | **0.5%** |
| **14,748** | **13,921** | **827** | **5.9%** | **OneCare Connect** | **132,018** | **126,247** | **5,771** | **4.6%** |
| **1,714** | **1,378** | **336** | **24.4%** | **OneCare** | **14,477** | **12,402** | **2,075** | **16.7%** |
| **388** | **451** | **(63)** | **(14.0%)** | **PACE** | **3,485** | **3,816** | **(331)** | **(8.7%)** |
| **826,368** | **811,919** | **14,449** | **1.8%** | **CalOptima Total** | **7,202,299** | **7,157,961** | **44,338** | **0.6%** |

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# Financial Highlights: March 2021

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| 826,368 | 811,919 | 14,449 | 1.8% | Member Months | 7,202,299 | 7,157,961 | 44,338 | 0.6% |
| 425,787,701 | 270,476,186 | 155,311,515 | 57.4% | Revenues | 3,034,711,981 | 2,740,451,444 | 294,260,537 | 10.7% |
| 418,880,810 | 268,503,431 | (150,377,379) | (56.0%) | Medical Expenses | 2,917,567,946 | 2,658,115,553 | (259,452,393) | (9.8%) |
| 11,800,246 | 13,233,418 | 1,433,172 | 10.8% | Administrative Expenses | 100,925,555 | 113,768,126 | 12,842,571 | 11.3% |
| **(4,893,355)** | **(11,260,663)** | **6,367,308** | **56.5%** | **Operating Margin** | **16,218,481** | **(31,432,235)** | **47,650,716** | **151.6%** |
| 741,375 | 1,250,000 | (508,625) | (40.7%) | Non Operating Income (Loss) | 5,366,830 | 11,250,000 | (5,883,170) | (52.3%) |
| **(4,151,980)** | **(10,010,663)** | **5,858,683** | **58.5%** | **Change in Net Assets** | **21,585,311** | **(20,182,235)** | **41,767,546** | **207.0%** |
| 98.4% | 99.3% | 0.9% | | Medical Loss Ratio | 96.1% | 97.0% | 0.9% | |
| 2.8% | 4.9% | 2.1% | | Administrative Loss Ratio | 3.3% | 4.2% | 0.8% | |
| (1.1%) | (4.2%) | 3.0% | | Operating Margin Ratio | 0.5% | (1.1%) | 1.7% | |
| 100.0% | 100.0% | | | Total Operating | 100.0% | 100.0% | | |
| 98.4% | 99.3% | 0.9% | | *MLR (excluding Directed Payments) | 95.9% | 97.0% | 1.1% | |
| 3.5% | 4.9% | 1.4% | | *ALR (excluding Directed Payments) | 3.6% | 4.2% | 0.6% | |

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

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

| MONTH-TO-DATE | | | | YEAR-TO-DATE | | |
|---|---|---|---|---|---|---|
| Actual | Budget | Variance | | Actual | Budget | Variance |
| (4.0) | (10.0) | 6.0 | Medi-Cal | 12.6 | (25.2) | 37.8 |
| 0.3 | (1.2) | 1.5 | OCC | 0.4 | (8.0) | 8.4 |
| (0.3) | (0.1) | (0.2) | OneCare | 0.0 | 0.2 | (0.2) |
| (0.9) | 0.0 | (1.0) | PACE | 3.2 | 1.6 | 1.6 |
| **(4.9)** | **(11.3)** | **6.4** | **Operating** | **16.2** | **(31.4)** | **47.7** |
| 0.7 | 1.3 | (0.5) | Inv./Rental Inc, MCO tax | 5.4 | 11.3 | (5.9) |
| **0.7** | **1.3** | **(0.5)** | **Non-Operating** | **5.4** | **11.3** | **(5.9)** |
| **(4.2)** | **(10.0)** | **5.9** | **TOTAL** | **21.6** | **(20.2)** | **41.8** |

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# Consolidated Revenue & Expenses: March 2021 MTD

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 519,491 | 278,096 | 11,931 | 809,518 | 14,748 | 1,714 | 388 | 826,368 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | 200,190,699 | $ 163,498,579 | $ 25,279,393 | $ 388,968,671 | $ 31,417,247 | $ 2,268,909 | $ 3,132,874 | $ 425,787,701 |
| **Total Operating Revenue** | 200,190,699 | 163,498,579 | 25,279,393 | 388,968,671 | 31,417,247 | 2,268,909 | 3,132,874 | 425,787,701 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 40,851,020 | 48,379,548 | 10,347,669 | 99,578,236 | 13,899,759 | 635,867 | | 114,113,862 |
| Facilities | 26,168,659 | 26,774,790 | 3,904,836 | 56,848,284 | 5,391,331 | 984,353 | 1,488,451 | 64,712,419 |
| Professional Claims | 20,853,143 | 10,173,477 | 1,340,283 | 32,366,903 | 1,060,808 | 46,600 | 947,943 | 34,422,254 |
| Prescription Drugs | 21,930,692 | 29,218,797 | 6,144,673 | 57,294,163 | 6,613,157 | 663,407 | 304,095 | 64,874,822 |
| MLTSS | 34,623,104 | 3,241,155 | 1,648,100 | 39,512,359 | 1,294,626 | 22,654 | 84,337 | 40,913,977 |
| Medical Management | 2,712,081 | 1,655,755 | 347,491 | 4,715,327 | 1,107,205 | 35,926 | 925,548 | 6,784,006 |
| Quality Incentives | 860,041 | 539,668 | 35,511 | 1,435,220 | 213,630 | | 4,850 | 1,653,700 |
| Reinsurance & Other | 52,833,155 | 38,291,144 | 11,203 | 91,135,502 | 90,501 | 25 | 179,742 | 91,405,770 |
| **Total Medical Expenses** | 200,831,895 | 158,274,334 | 23,779,766 | 382,885,995 | 29,671,017 | 2,388,832 | 3,934,967 | 418,880,810 |
| **Medical Loss Ratio** | 100.3% | 96.8% | 94.1% | 98.4% | 94.4% | 105.3% | 125.6% | 98.4% |
| **GROSS MARGIN** | **(641,196)** | **5,224,245** | **1,499,627** | **6,082,676** | **1,746,230** | **(119,923)** | **(802,092)** | **6,906,891** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 7,258,589 | 724,424 | 85,412 | 107,360 | 8,175,784 |
| Professional fees | | | | 81,663 | 5,333 | 16,000 | 123 | 103,120 |
| Purchased services | | | | 836,020 | 153,767 | 9,430 | 5,207 | 1,004,424 |
| Printing & Postage | | | | 250,116 | 87,137 | 3,763 | 18,280 | 359,296 |
| Depreciation & Amortization | | | | 602,034 | | | 2,013 | 604,047 |
| Other expenses | | | | 1,225,922 | (301) | 448 | 5,449 | 1,231,518 |
| Indirect cost allocation & Occupancy | | | | (195,929) | 480,751 | 35,551 | 1,683 | 322,056 |
| **Total Administrative Expenses** | | | | 10,058,415 | 1,451,111 | 150,604 | 140,116 | 11,800,246 |
| **Admin Loss Ratio** | | | | 2.6% | 4.6% | 6.6% | 4.5% | 2.8% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | (3,975,739) | 295,119 | (270,527) | (942,208) | (4,893,355) |
| **INVESTMENT INCOME** | | | | | | | | (422,421) |
| **TOTAL MCO TAX** | | | | 1,163,291 | | | | 1,163,291 |
| **OTHER INCOME** | | | | 505 | | | | 505 |
| **CHANGE IN NET ASSETS** | | | | **$ (2,811,943)** | **$ 295,119** | **$ (270,527)** | **$ (942,208)** | **$ (4,151,980)** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | (10,014,005) | (1,211,964) | (75,468) | 40,774 | (10,010,663) |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ 7,202,062 | $ 1,507,083 | $ (195,059) | $ (982,982) | $ 5,858,683 |

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# Consolidated Revenue & Expenses: March 2021 YTD

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 4,591,833 | 2,356,452 | 104,034 | 7,052,319 | 132,018 | 14,477 | 3,485 | 7,202,299 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | 1,416,365,978 | $ 1,102,566,828 | $ 211,204,759 | $ 2,730,137,566 | $ 257,226,549 | $ 18,189,137 | $ 29,158,730 | $ 3,034,711,981 |
| **Total Operating Revenue** | 1,416,365,978 | 1,102,566,828 | 211,204,759 | 2,730,137,566 | 257,226,549 | 18,189,137 | 29,158,730 | 3,034,711,981 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 340,431,614 | 402,771,129 | 108,225,413 | 851,428,156 | 110,109,104 | 5,018,111 | | 966,555,372 |
| Facilities | 215,882,066 | 227,186,901 | 15,892,333 | 458,961,300 | 45,120,485 | 5,185,547 | 6,748,173 | 516,015,505 |
| Professional Claims | 178,163,948 | 82,792,134 | 9,521,520 | 270,477,601 | 8,904,997 | 637,869 | 5,761,223 | 285,781,691 |
| Prescription Drugs | 180,570,421 | 228,689,462 | 48,060,901 | 457,320,784 | 53,744,288 | 5,354,411 | 2,572,685 | 518,992,168 |
| MLTSS | 301,813,427 | 25,801,251 | 16,774,507 | 344,389,184 | 12,570,172 | 264,224 | 572,431 | 357,796,011 |
| Medical Management | 21,275,359 | 12,645,752 | 2,676,463 | 36,597,575 | 9,750,464 | 326,502 | 7,728,615 | 54,403,156 |
| Quality Incentives | 9,790,962 | 4,655,982 | 526,770 | 14,973,713 | 1,945,755 | | 127,922 | 17,047,390 |
| Reinsurance & Other | 112,582,384 | 86,071,084 | 108,068 | 198,761,536 | 1,187,283 | 25 | 1,027,810 | 200,976,654 |
| **Total Medical Expenses** | 1,360,510,181 | 1,070,613,695 | 201,785,975 | 2,632,909,851 | 243,332,548 | 16,786,688 | 24,538,859 | 2,917,567,946 |
| **Medical Loss Ratio** | 96.1% | 97.1% | 95.5% | 96.4% | 94.6% | 92.3% | 84.2% | 96.1% |
| **GROSS MARGIN** | **55,855,798** | **31,953,133** | **9,418,784** | **97,227,715** | **13,894,001** | **1,402,448** | **4,619,871** | **117,144,036** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 61,440,393 | 6,298,338 | 745,617 | 1,035,221 | 69,519,569 |
| Professional fees | | | | 1,107,446 | 154,363 | 156,973 | 1,150 | 1,419,932 |
| Purchased services | | | | 7,266,952 | 799,920 | 74,629 | 134,044 | 8,275,545 |
| Printing & Postage | | | | 2,101,128 | 724,409 | 50,412 | 115,760 | 2,991,709 |
| Depreciation & Amortization | | | | 2,905,683 | | | 18,233 | 2,923,916 |
| Other expenses | | | | 12,344,768 | 258,561 | 653 | 42,575 | 12,646,557 |
| Indirect cost allocation & Occupancy | | | | (2,531,441) | 5,273,988 | 372,937 | 32,843 | 3,148,327 |
| **Total Administrative Expenses** | | | | 84,634,928 | 13,509,579 | 1,401,221 | 1,379,827 | 100,925,555 |
| **Admin Loss Ratio** | | | | 3.1% | 5.3% | 7.7% | 4.7% | 3.3% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | 12,592,786 | 384,422 | 1,227 | 3,240,045 | 16,218,481 |
| **INVESTMENT INCOME** | | | | | | | | 4,692,451 |
| **TOTAL MCO TAX** | | | | 659,494 | | | | 659,494 |
| **TOTAL GRANT INCOME** | | | | 14,050 | | | | 14,050 |
| **OTHER INCOME** | | | | 835 | | | | 835 |
| **CHANGE IN NET ASSETS** | | | | **$ 13,267,166** | **$ 384,422** | **$ 1,227** | **$ 3,240,045** | **$ 21,585,311** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | (25,240,083) | (7,972,608) | 170,602 | 1,609,854 | (20,182,235) |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ 38,507,249 | $ 8,357,030 | $ (169,375) | $ 1,630,191 | $ 41,767,546 |

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# Balance Sheet: As of March 2021

**ASSETS**

| | |
|---|---|
| Current Assets | |
| Operating Cash | $416,486,933 |
| Investments | 933,965,135 |
| Capitation receivable | 322,713,706 |
| Receivables - Other | 45,590,643 |
| Prepaid expenses | 8,174,739 |
| **Total Current Assets** | **1,726,931,156** |
| Capital Assets | |
| Furniture & Equipment | 46,910,603 |
| Building/Leasehold Improvements | 5,388,527 |
| 505 City Parkway West | 51,646,314 |
| | 103,945,443 |
| Less: accumulated depreciation | (58,186,289) |
| Capital assets, net | 45,759,154 |
| Other Assets | |
| Restricted Deposit & Other | 300,000 |
| Homeless Health Reserve | 56,798,913 |
| Board-designated assets: | |
| Cash and Cash Equivalents | 1,274,715 |
| Long-term Investments | 586,802,263 |
| Total Board-designated Assets | 588,076,978 |
| **Total Other Assets** | 645,175,891 |
| **TOTAL ASSETS** | **2,417,866,201** |
| Deferred Outflows | |
| Contributions | 1,047,297 |
| Difference in Experience | 4,280,308 |
| Excess Earning | - |
| Changes in Assumptions | 5,060,465 |
| OPEB 75 Changes in Assumptions | 703,000 |
| Pension Contributions | 570,000 |
| **TOTAL ASSETS & DEFERRED OUTFLOWS** | **2,429,527,271** |

**LIABILITIES & NET POSITION**

| | |
|---|---|
| Current Liabilities | |
| Accounts Payable | $45,422,050 |
| Medical Claims liability | 1,108,232,503 |
| Accrued Payroll Liabilities | 17,748,731 |
| Deferred Revenue | 17,295,401 |
| Deferred Lease Obligations | 135,860 |
| Capitation and Withholds | 133,732,561 |
| **Total Current Liabilities** | **1,322,567,107** |
| Other (than pensions) post employment benefits liability | 26,212,000 |
| Net Pension Liabilities | 27,354,284 |
| Bldg 505 Development Rights | - |
| **TOTAL LIABILITIES** | **1,376,133,391** |
| Deferred Inflows | |
| Excess Earnings | 506,547 |
| OPEB 75 Difference in Experience | 804,000 |
| Change in Assumptions | 3,728,725 |
| OPEB Changes in Assumptions | 1,638,000 |
| Net Position | |
| TNE | 103,809,007 |
| Funds in Excess of TNE | 942,907,601 |
| **TOTAL NET POSITION** | 1,046,716,608 |
| **TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION** | **2,429,527,271** |

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# Board Designated Reserve and TNE Analysis: As of March 2021

| Type | Reserve Name | Market Value | Benchmark | | Variance | |
|---|---|---|---|---|---|---|
| | | | Low | High | Mkt - Low | Mkt - High |
| | Tier 1 - Payden & Rygel | 160,891,432 | | | | |
| | Tier 1 - MetLife | 159,855,745 | | | | |
| | Tier 1 - Wells Capital | 160,050,415 | | | | |
| Board-designated Reserve | | | | | | |
| | | 480,797,591 | 329,418,600 | 515,087,574 | 151,378,991 | (34,289,983) |
| TNE Requirement | Tier 2 - MetLife | 107,279,387 | 103,809,007 | 103,809,007 | 3,470,380 | 3,470,380 |
| | **Consolidated:** | **588,076,978** | **433,227,607** | **618,896,581** | **154,849,371** | **(30,819,603)** |
| | *Current reserve level* | *1.90* | *1.40* | *2.00* | | |

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# Our Mission

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

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# UNAUDITED FINANCIAL STATEMENTS

# March 31, 2021

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# March 31, 2021 Unaudited Financial Statements

## SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($4.2) million, $5.9 million favorable to budget
- Operating deficit is $4.9 million, with a surplus in non-operating income of $0.7 million

## YEAR TO DATE RESULTS:

- Change in Net Assets is $21.6 million, $41.8 million favorable to budget
- Operating surplus is $16.2 million, with a surplus in non-operating income of $5.4 million
- Investment Income & Other unfavorable variance due to decrease in long-term bond values that are affected by higher interest rates

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

| MONTH-TO-DATE | | | | YEAR-TO-DATE | | |
|---|---|---|---|---|---|---|
| Actual | Budget | Variance | | Actual | Budget | Variance |
| (4.0) | (10.0) | 6.0 | Medi-Cal | 12.6 | (25.2) | 37.8 |
| 0.3 | (1.2) | 1.5 | OCC | 0.4 | (8.0) | 8.4 |
| (0.3) | (0.1) | (0.2) | OneCare | 0.0 | 0.2 | (0.2) |
| (0.9) | 0.0 | (1.0) | PACE | 3.2 | 1.6 | 1.6 |
| **(4.9)** | **(11.3)** | **6.4** | **Operating** | **16.2** | **(31.4)** | **47.7** |
| 0.7 | 1.3 | (0.5) | Inv./Rental Inc, MCO tax | 5.4 | 11.3 | (5.9) |
| **0.7** | **1.3** | **(0.5)** | **Non-Operating** | **5.4** | **11.3** | **(5.9)** |
| **(4.2)** | **(10.0)** | **5.9** | **TOTAL** | **21.6** | **(20.2)** | **41.8** |

# CalOptima
# Financial Dashboard
# For the Nine Months Ended March 31, 2021

## MONTH - TO - DATE

| Enrollment | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | 809,518 | 796,169 | ↑ | 13,349 | 1.7% |
| OneCare Connect | 14,748 | 13,921 | ↑ | 827 | 5.9% |
| OneCare | 1,714 | 1,378 | ↑ | 336 | 24.4% |
| PACE | 388 | 451 | ↓ | (63) | (14.0%) |
| Total | 826,368 | 811,919 | ↑ | 14,449 | 1.8% |

| Change in Net Assets (000) | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ (2,812) | $ (10,014) | ↑ | $ 7,202 | 71.9% |
| OneCare Connect | 295 | (1,212) | ↑ | 1,507 | 124.3% |
| OneCare | (271) | (75) | ↓ | (196) | (261.3%) |
| PACE | (942) | 41 | ↓ | (983) | (2397.6%) |
| 505 Bldg. | - | - | ↑ | - | 0.0% |
| Investment Income & Other | (422) | 1,250 | ↓ | (1,672) | (133.8%) |
| Total | $ (4,152) | $ (10,010) | ↑ | $ 5,858 | 58.5% |

| MLR | Actual | Budget | | % Point Var |
|---|---|---|---|---|
| Medi-Cal | 98.4% | 99.5% | ↑ | 1.1 |
| OneCare Connect | 94.4% | 98.1% | ↑ | 3.7 |
| OneCare | 105.3% | 95.8% | ↓ | (9.5) |

| Administrative Cost (000) | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ 10,058 | $ 11,205 | ↑ | $ 1,146 | 10.2% |
| OneCare Connect | 1,451 | 1,680 | ↑ | 229 | 13.6% |
| OneCare | 151 | 141 | ↓ | (10) | (7.0%) |
| PACE | 140 | 208 | ↑ | 68 | 32.7% |
| Total | $ 11,800 | $ 13,233 | ↑ | $ 1,433 | 10.8% |

| Total FTE's Month | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 1,070 | 1,161 | 91 |
| OneCare Connect | 197 | 210 | 13 |
| OneCare | 10 | 9 | (1) |
| PACE | 96 | 116 | 21 |
| Total | 1,372 | 1,496 | 124 |

| MM per FTE | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 757 | 686 | 71 |
| OneCare Connect | 75 | 66 | 9 |
| OneCare | 171 | 148 | 23 |
| PACE | 4 | 4 | 0 |
| Total | 1,007 | 904 | 102 |

## YEAR - TO - DATE

| Year To Date Enrollment | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | 7,052,319 | 7,015,496 | ↑ | 36,823 | 0.5% |
| OneCare Connect | 132,018 | 126,247 | ↑ | 5,771 | 4.6% |
| OneCare | 14,477 | 12,402 | ↑ | 2,075 | 16.7% |
| PACE | 3,485 | 3,816 | ↓ | (331) | (8.7%) |
| Total | 7,202,299 | 7,157,961 | ↑ | 44,338 | 0.6% |

| Change in Net Assets (000) | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ 13,267 | $ (25,240) | ↑ | $ 38,507 | 152.6% |
| OneCare Connect | 384 | (7,973) | ↑ | 8,357 | 104.8% |
| OneCare | 1 | 171 | ↓ | (170) | (99.4%) |
| PACE | 3,240 | 1,610 | ↑ | 1,630 | 101.2% |
| 505 Bldg. | - | - | ↑ | - | 0.0% |
| Investment Income & Other | 4,692 | 11,250 | ↓ | (6,558) | (58.3%) |
| Total | $ 21,584 | $ (20,182) | ↑ | $ 41,766 | 206.9% |

| MLR | Actual | Budget | | % Point Var |
|---|---|---|---|---|
| Medi-Cal | 96.4% | 97.1% | ↑ | 0.7 |
| OneCare Connect | 94.6% | 97.2% | ↑ | 2.6 |
| OneCare | 92.3% | 90.5% | ↓ | (1.8) |

| Administrative Cost (000) | Actual | Budget | | Fav / (Unfav) | |
|---|---|---|---|---|---|
| Medi-Cal | $ 84,635 | $ 96,392 | ↑ | $ 11,757 | 12.2% |
| OneCare Connect | 13,510 | 14,517 | ↑ | 1,007 | 6.9% |
| OneCare | 1,401 | 1,232 | ↓ | (169) | (13.7%) |
| PACE | 1,380 | 1,627 | ↑ | 247 | 15.2% |
| Total | $ 100,926 | $ 113,768 | ↑ | $ 12,843 | 11.3% |

| Total FTE's YTD | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 9,722 | 10,447 | 725 |
| OneCare Connect | 1,723 | 1,888 | 165 |
| OneCare | 90 | 84 | (7) |
| PACE | 827 | 1,046 | 219 |
| Total | 12,362 | 13,465 | 1,102 |

| MM per FTE | Actual | Budget | Fav / (Unfav) |
|---|---|---|---|
| Medi-Cal | 725 | 672 | 54 |
| OneCare Connect | 77 | 67 | 10 |
| OneCare | 160 | 148 | 12 |
| PACE | 4 | 4 | 1 |
| Total | 966 | 890 | 76 |

**CalOptima - Consolidated**
**Statement of Revenues and Expenses**
**For the One Month Ended March 31, 2021**

| | Actual | | Budget | | Variance | |
|---|---|---|---|---|---|---|
| | $ | PMPM | $ | PMPM | $ | PMPM |
| **MEMBER MONTHS** | 826,368 | | 811,919 | | 14,449 | |
| **REVENUE** | | | | | | |
| Medi-Cal | $ 388,968,671 | $ 480.49 | $ 240,091,608 | $ 301.56 | $ 148,877,063 | $ 178.93 |
| OneCare Connect | 31,417,247 | 2,130.27 | 25,188,021 | 1,809.35 | 6,229,226 | 320.92 |
| OneCare | 2,268,909 | 1,323.75 | 1,556,070 | 1,129.22 | 712,839 | 194.53 |
| PACE | 3,132,874 | 8,074.42 | 3,640,487 | 8,072.03 | (507,613) | 2.39 |
| Total Operating Revenue | 425,787,701 | 515.25 | 270,476,186 | 333.13 | 155,311,515 | 182.12 |
| **MEDICAL EXPENSES** | | | | | | |
| Medi-Cal | 382,885,995 | 472.98 | 238,901,113 | 300.06 | (143,984,882) | (172.92) |
| OneCare Connect | 29,671,017 | 2,011.87 | 24,719,861 | 1,775.72 | (4,951,156) | (236.15) |
| OneCare | 2,388,832 | 1,393.72 | 1,490,834 | 1,081.88 | (897,998) | (311.84) |
| PACE | 3,934,967 | 10,141.67 | 3,391,623 | 7,520.23 | (543,344) | (2,621.44) |
| Total Medical Expenses | 418,880,810 | 506.89 | 268,503,431 | 330.70 | (150,377,379) | (176.19) |
| **GROSS MARGIN** | 6,906,891 | 8.36 | 1,972,755 | 2.43 | 4,934,136 | 5.93 |
| **ADMINISTRATIVE EXPENSES** | | | | | | |
| Salaries and benefits | 8,175,784 | 9.89 | 8,590,777 | 10.58 | 414,993 | 0.69 |
| Professional fees | 103,120 | 0.12 | 376,770 | 0.46 | 273,650 | 0.34 |
| Purchased services | 1,004,424 | 1.22 | 1,086,326 | 1.34 | 81,902 | 0.12 |
| Printing & Postage | 359,296 | 0.43 | 640,984 | 0.79 | 281,688 | 0.36 |
| Depreciation & Amortization | 604,047 | 0.73 | 460,570 | 0.57 | (143,477) | (0.16) |
| Other expenses | 1,231,518 | 1.49 | 1,699,368 | 2.09 | 467,850 | 0.60 |
| Indirect cost allocation & Occupancy expense | 322,056 | 0.39 | 378,623 | 0.47 | 56,567 | 0.08 |
| Total Administrative Expenses | 11,800,246 | 14.28 | 13,233,418 | 16.30 | 1,433,172 | 2.02 |
| **INCOME (LOSS) FROM OPERATIONS** | (4,893,355) | (5.92) | (11,260,663) | (13.87) | 6,367,308 | 7.95 |
| **INVESTMENT INCOME** | | | | | | |
| Interest income | 688,595 | 0.83 | 1,250,000 | 1.54 | (561,405) | (0.71) |
| Realized gain/(loss) on investments | 757,661 | 0.92 | - | - | 757,661 | 0.92 |
| Unrealized gain/(loss) on investments | (1,868,677) | (2.26) | - | - | (1,868,677) | (2.26) |
| Total Investment Income | (422,421) | (0.51) | 1,250,000 | 1.54 | (1,672,421) | (2.05) |
| **TOTAL MCO TAX** | 1,163,291 | 1.41 | (0) | - | 1,163,291 | 1.41 |
| **OTHER INCOME** | 505 | - | - | - | 505 | - |
| **CHANGE IN NET ASSETS** | **(4,151,980)** | **(5.02)** | **(10,010,663)** | **(12.33)** | **5,858,683** | **7.31** |
| **MEDICAL LOSS RATIO** | **98.4%** | | **99.3%** | | **0.9%** | |
| **ADMINISTRATIVE LOSS RATIO** | **2.8%** | | **4.9%** | | **2.1%** | |

**CalOptima - Consolidated**
**Statement of Revenues and Expenses**
**For the Nine Months Ended March 31, 2021**

| | Actual | | Budget | | Variance | |
|---|---|---|---|---|---|---|
| | $ | PMPM | $ | PMPM | $ | PMPM |
| **MEMBER MONTHS** | 7,202,299 | | 7,157,961 | | 44,338 | |
| **REVENUE** | | | | | | |
| Medi-Cal | $ 2,730,137,566 | $ 387.13 | $ 2,464,015,804 | $ 351.22 | $ 266,121,762 | $ 35.91 |
| OneCare Connect | 257,226,549 | 1,948.42 | 230,703,418 | 1,827.40 | 26,523,131 | 121.02 |
| OneCare | 18,189,137 | 1,256.42 | 14,793,577 | 1,192.84 | 3,395,560 | 63.58 |
| PACE | 29,158,730 | 8,366.92 | 30,938,645 | 8,107.61 | (1,779,915) | 259.31 |
| Total Operating Revenue | 3,034,711,981 | 421.35 | 2,740,451,444 | 382.85 | 294,260,537 | 38.50 |
| **MEDICAL EXPENSES** | | | | | | |
| Medi-Cal | 2,632,909,851 | 373.34 | 2,392,864,054 | 341.08 | (240,045,797) | (32.26) |
| OneCare Connect | 243,332,548 | 1,843.18 | 224,159,095 | 1,775.56 | (19,173,453) | (67.62) |
| OneCare | 16,786,688 | 1,159.54 | 13,390,919 | 1,079.74 | (3,395,769) | (79.80) |
| PACE | 24,538,859 | 7,041.28 | 27,701,485 | 7,259.30 | 3,162,626 | 218.02 |
| Total Medical Expenses | 2,917,567,946 | 405.09 | 2,658,115,553 | 371.35 | (259,452,393) | (33.74) |
| **GROSS MARGIN** | 117,144,036 | 16.26 | 82,335,891 | 11.50 | 34,808,145 | 4.76 |
| **ADMINISTRATIVE EXPENSES** | | | | | | |
| Salaries and benefits | 69,519,569 | 9.65 | 71,377,603 | 9.97 | 1,858,034 | 0.32 |
| Professional fees | 1,419,932 | 0.20 | 3,353,790 | 0.47 | 1,933,858 | 0.27 |
| Purchased services | 8,275,545 | 1.15 | 10,954,685 | 1.53 | 2,679,140 | 0.38 |
| Printing & Postage | 2,991,709 | 0.42 | 5,221,356 | 0.73 | 2,229,647 | 0.31 |
| Depreciation & Amortization | 2,923,916 | 0.41 | 4,145,130 | 0.58 | 1,221,214 | 0.17 |
| Other expenses | 12,646,557 | 1.76 | 15,271,183 | 2.13 | 2,624,626 | 0.37 |
| Indirect cost allocation & Occupancy expense | 3,148,327 | 0.44 | 3,444,379 | 0.48 | 296,052 | 0.04 |
| Total Administrative Expenses | 100,925,555 | 14.01 | 113,768,126 | 15.89 | 12,842,571 | 1.88 |
| **INCOME (LOSS) FROM OPERATIONS** | 16,218,481 | 2.25 | (31,432,235) | (4.39) | 47,650,716 | 6.64 |
| **INVESTMENT INCOME** | | | | | | |
| Interest income | 8,721,304 | 1.21 | 11,250,000 | 1.57 | (2,528,696) | (0.36) |
| Realized gain/(loss) on investments | 5,027,209 | 0.70 | - | - | 5,027,209 | 0.70 |
| Unrealized gain/(loss) on investments | (9,056,062) | (1.26) | - | - | (9,056,062) | (1.26) |
| Total Investment Income | 4,692,451 | 0.65 | 11,250,000 | 1.57 | (6,557,549) | (0.92) |
| **TOTAL MCO TAX** | 659,494 | 0.09 | - | - | 659,494 | 0.09 |
| **TOTAL GRANT INCOME** | 14,050 | - | - | - | 14,050 | - |
| **OTHER INCOME** | 835 | - | - | - | 835 | - |
| **CHANGE IN NET ASSETS** | **21,585,311** | **3.00** | **(20,182,235)** | **(2.82)** | **41,767,546** | **5.82** |
| **MEDICAL LOSS RATIO** | **96.1%** | | **97.0%** | | **0.9%** | |
| **ADMINISTRATIVE LOSS RATIO** | **3.3%** | | **4.2%** | | **0.8%** | |

# CalOptima - Consolidated - Month to Date
# Statement of Revenues and Expenses by LOB
# For the One Month Ended March 31, 2021

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 519,491 | 278,096 | 11,931 | 809,518 | 14,748 | 1,714 | 388 | 826,368 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | 200,190,699 | $ 163,498,579 | $ 25,279,393 | $ 388,968,671 | $ 31,417,247 | $ 2,268,909 | $ 3,132,874 | $ 425,787,701 |
| **Total Operating Revenue** | 200,190,699 | 163,498,579 | 25,279,393 | 388,968,671 | 31,417,247 | 2,268,909 | 3,132,874 | 425,787,701 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 40,851,020 | 48,379,548 | 10,347,669 | 99,578,236 | 13,899,759 | 635,867 | | 114,113,862 |
| Facilities | 26,168,659 | 26,774,790 | 3,904,836 | 56,848,284 | 5,391,331 | 984,353 | 1,488,451 | 64,712,419 |
| Professional Claims | 20,853,143 | 10,173,477 | 1,340,283 | 32,366,903 | 1,060,808 | 46,600 | 947,943 | 34,422,254 |
| Prescription Drugs | 21,930,692 | 29,218,797 | 6,144,673 | 57,294,163 | 6,613,157 | 663,407 | 304,095 | 64,874,822 |
| MLTSS | 34,623,104 | 3,241,155 | 1,648,100 | 39,512,359 | 1,294,626 | 22,654 | 84,337 | 40,913,977 |
| Medical Management | 2,712,081 | 1,655,755 | 347,491 | 4,715,327 | 1,107,205 | 35,926 | 925,548 | 6,784,006 |
| Quality Incentives | 860,041 | 539,668 | 35,511 | 1,435,220 | 213,630 | | 4,850 | 1,653,700 |
| Reinsurance & Other | 52,833,155 | 38,291,144 | 11,203 | 91,135,502 | 90,501 | 25 | 179,742 | 91,405,770 |
| **Total Medical Expenses** | 200,831,895 | 158,274,334 | 23,779,766 | 382,885,995 | 29,671,017 | 2,388,832 | 3,934,967 | 418,880,810 |
| **Medical Loss Ratio** | 100.3% | 96.8% | 94.1% | 98.4% | 94.4% | 105.3% | 125.6% | 98.4% |
| **GROSS MARGIN** | **(641,196)** | **5,224,245** | **1,499,627** | **6,082,676** | **1,746,230** | **(119,923)** | **(802,092)** | **6,906,891** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 7,258,589 | 724,424 | 85,412 | 107,360 | 8,175,784 |
| Professional fees | | | | 81,663 | 5,333 | 16,000 | 123 | 103,120 |
| Purchased services | | | | 836,020 | 153,767 | 9,430 | 5,207 | 1,004,424 |
| Printing & Postage | | | | 250,116 | 87,137 | 3,763 | 18,280 | 359,296 |
| Depreciation & Amortization | | | | 602,034 | | | 2,013 | 604,047 |
| Other expenses | | | | 1,225,922 | (301) | 448 | 5,449 | 1,231,518 |
| Indirect cost allocation & Occupancy | | | | (195,929) | 480,751 | 35,551 | 1,683 | 322,056 |
| **Total Administrative Expenses** | | | | 10,058,415 | 1,451,111 | 150,604 | 140,116 | 11,800,246 |
| **Admin Loss Ratio** | | | | 2.6% | 4.6% | 6.6% | 4.5% | 2.8% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | (3,975,739) | 295,119 | (270,527) | (942,208) | (4,893,355) |
| **INVESTMENT INCOME** | | | | | | | | (422,421) |
| **TOTAL MCO TAX** | | | | 1,163,291 | | | | 1,163,291 |
| **OTHER INCOME** | | | | 505 | | | | 505 |
| **CHANGE IN NET ASSETS** | | | | **$ (2,811,943)** | **$ 295,119** | **$ (270,527)** | **$ (942,208)** | **$ (4,151,980)** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | (10,014,005) | (1,211,964) | (75,468) | 40,774 | (10,010,663) |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ 7,202,062 | $ 1,507,083 | $ (195,059) | $ (982,982) | $ 5,858,683 |

**CalOptima - Consolidated - Year to Date**
**Statement of Revenues and Expenses by LOB**
**For the Nine Months Ended March 31, 2021**

| | Medi-Cal Classic | Medi-Cal Expansion | Whole Child Model | Total Medi-Cal | OneCare Connect | OneCare | PACE | Consolidated |
|---|---|---|---|---|---|---|---|---|
| **MEMBER MONTHS** | 4,591,833 | 2,356,452 | 104,034 | 7,052,319 | 132,018 | 14,477 | 3,485 | 7,202,299 |
| **REVENUES** | | | | | | | | |
| Capitation Revenue | 1,416,365,978 | $ 1,102,566,828 | $ 211,204,759 | $ 2,730,137,566 | $ 257,226,549 | $ 18,189,137 | $ 29,158,730 | $ 3,034,711,981 |
| **Total Operating Revenue** | 1,416,365,978 | 1,102,566,828 | 211,204,759 | 2,730,137,566 | 257,226,549 | 18,189,137 | 29,158,730 | 3,034,711,981 |
| **MEDICAL EXPENSES** | | | | | | | | |
| Provider Capitation | 340,431,614 | 402,771,129 | 108,225,413 | 851,428,156 | 110,109,104 | 5,018,111 | | 966,555,372 |
| Facilities | 215,882,066 | 227,186,901 | 15,892,333 | 458,961,300 | 45,120,485 | 5,185,547 | 6,748,173 | 516,015,505 |
| Professional Claims | 178,163,948 | 82,792,134 | 9,521,520 | 270,477,601 | 8,904,997 | 637,869 | 5,761,223 | 285,781,691 |
| Prescription Drugs | 180,570,421 | 228,689,462 | 48,060,901 | 457,320,784 | 53,744,288 | 5,354,411 | 2,572,685 | 518,992,168 |
| MLTSS | 301,813,427 | 25,801,251 | 16,774,507 | 344,389,184 | 12,570,172 | 264,224 | 572,431 | 357,796,011 |
| Medical Management | 21,275,359 | 12,645,752 | 2,676,463 | 36,597,575 | 9,750,464 | 326,502 | 7,728,615 | 54,403,156 |
| Quality Incentives | 9,790,962 | 4,655,982 | 526,770 | 14,973,713 | 1,945,755 | | 127,922 | 17,047,390 |
| Reinsurance & Other | 112,582,384 | 86,071,084 | 108,068 | 198,761,536 | 1,187,283 | 25 | 1,027,810 | 200,976,654 |
| **Total Medical Expenses** | 1,360,510,181 | 1,070,613,695 | 201,785,975 | 2,632,909,851 | 243,332,548 | 16,786,688 | 24,538,859 | 2,917,567,946 |
| **Medical Loss Ratio** | 96.1% | 97.1% | 95.5% | 96.4% | 94.6% | 92.3% | 84.2% | 96.1% |
| **GROSS MARGIN** | **55,855,798** | **31,953,133** | **9,418,784** | **97,227,715** | **13,894,001** | **1,402,448** | **4,619,871** | **117,144,036** |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | |
| Salaries & Benefits | | | | 61,440,393 | 6,298,338 | 745,617 | 1,035,221 | 69,519,569 |
| Professional fees | | | | 1,107,446 | 154,363 | 156,973 | 1,150 | 1,419,932 |
| Purchased services | | | | 7,266,952 | 799,920 | 74,629 | 134,044 | 8,275,545 |
| Printing & Postage | | | | 2,101,128 | 724,409 | 50,412 | 115,760 | 2,991,709 |
| Depreciation & Amortization | | | | 2,905,683 | | | 18,233 | 2,923,916 |
| Other expenses | | | | 12,344,768 | 258,561 | 653 | 42,575 | 12,646,557 |
| Indirect cost allocation & Occupancy | | | | (2,531,441) | 5,273,988 | 372,937 | 32,843 | 3,148,327 |
| **Total Administrative Expenses** | | | | 84,634,928 | 13,509,579 | 1,401,221 | 1,379,827 | 100,925,555 |
| **Admin Loss Ratio** | | | | 3.1% | 5.3% | 7.7% | 4.7% | 3.3% |
| **INCOME (LOSS) FROM OPERATIONS** | | | | 12,592,786 | 384,422 | 1,227 | 3,240,045 | 16,218,481 |
| **INVESTMENT INCOME** | | | | | | | | 4,692,451 |
| **TOTAL MCO TAX** | | | | 659,494 | | | | 659,494 |
| **TOTAL GRANT INCOME** | | | | 14,050 | | | | 14,050 |
| **OTHER INCOME** | | | | 835 | | | | 835 |
| **CHANGE IN NET ASSETS** | | | | **$ 13,267,166** | **$ 384,422** | **$ 1,227** | **$ 3,240,045** | **$ 21,585,311** |
| **BUDGETED CHANGE IN NET ASSETS** | | | | (25,240,083) | (7,972,608) | 170,602 | 1,609,854 | (20,182,235) |
| **VARIANCE TO BUDGET - FAV (UNFAV)** | | | | $ 38,507,249 | $ 8,357,030 | $ (169,375) | $ 1,630,191 | $ 41,767,546 |

# CalOptima - Consolidated
# Financial Highlights
# For the Nine Months Ended March 31, 2021

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| 826,368 | 811,919 | 14,449 | 1.8% | Member Months | 7,202,299 | 7,157,961 | 44,338 | 0.6% |
| 425,787,701 | 270,476,186 | 155,311,515 | 57.4% | Revenues | 3,034,711,981 | 2,740,451,444 | 294,260,537 | 10.7% |
| 418,880,810 | 268,503,431 | (150,377,379) | (56.0%) | Medical Expenses | 2,917,567,946 | 2,658,115,553 | (259,452,393) | (9.8%) |
| 11,800,246 | 13,233,418 | 1,433,172 | 10.8% | Administrative Expenses | 100,925,555 | 113,768,126 | 12,842,571 | 11.3% |
| **(4,893,355)** | **(11,260,663)** | **6,367,308** | **56.5%** | **Operating Margin** | **16,218,481** | **(31,432,235)** | **47,650,716** | **151.6%** |
| 741,375 | 1,250,000 | (508,625) | (40.7%) | Non Operating Income (Loss) | 5,366,830 | 11,250,000 | (5,883,170) | (52.3%) |
| **(4,151,980)** | **(10,010,663)** | **5,858,683** | **58.5%** | **Change in Net Assets** | **21,585,311** | **(20,182,235)** | **41,767,546** | **207.0%** |
| 98.4% | 99.3% | 0.9% | | Medical Loss Ratio | 96.1% | 97.0% | 0.9% | |
| 2.8% | 4.9% | 2.1% | | Administrative Loss Ratio | 3.3% | 4.2% | 0.8% | |
| (1.1%) | (4.2%) | 3.0% | | Operating Margin Ratio | 0.5% | (1.1%) | 1.7% | |
| 100.0% | 100.0% | | | Total Operating | 100.0% | 100.0% | | |
| 98.4% | 99.3% | 0.9% | | *MLR (excluding Directed Payments) | 95.9% | 97.0% | 1.1% | |
| 3.5% | 4.9% | 1.4% | | *ALR (excluding Directed Payments) | 3.6% | 4.2% | 0.6% | |

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

**CalOptima - Consolidated**
**Enrollment Summary**
**For the Nine Months Ended March 31, 2021**

| Month-to-Date | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | Enrollment (by Aid Category) | Actual | Budget | $ Variance | % Variance |
| 116,343 | 111,092 | 5,251 | 4.7% | SPD | 1,031,924 | 998,409 | 33,515 | 3.4% |
| 515 | 466 | 49 | 10.5% | BCCTP | 4,632 | 4,304 | 328 | 7.6% |
| 295,579 | 318,510 | (22,931) | (7.2%) | TANF Child | 2,630,773 | 2,791,415 | (160,642) | (5.8%) |
| 104,106 | 95,718 | 8,388 | 8.8% | TANF Adult | 895,594 | 839,357 | 56,237 | 6.7% |
| 2,948 | 3,521 | (573) | (16.3%) | LTC | 28,910 | 31,617 | (2,707) | (8.6%) |
| 278,096 | 254,929 | 23,167 | 9.1% | MCE | 2,356,452 | 2,243,008 | 113,444 | 5.1% |
| 11,931 | 11,933 | (2) | (0.0%) | WCM | 104,034 | 107,386 | (3,352) | (3.1%) |
| **809,518** | **796,169** | **13,349** | **1.7%** | **Medi-Cal Total** | **7,052,319** | **7,015,496** | **36,823** | **0.5%** |
| **14,748** | **13,921** | **827** | **5.9%** | **OneCare Connect** | **132,018** | **126,247** | **5,771** | **4.6%** |
| **1,714** | **1,378** | **336** | **24.4%** | **OneCare** | **14,477** | **12,402** | **2,075** | **16.7%** |
| **388** | **451** | **(63)** | **(14.0%)** | **PACE** | **3,485** | **3,816** | **(331)** | **(8.7%)** |
| **826,368** | **811,919** | **14,449** | **1.8%** | **CalOptima Total** | **7,202,299** | **7,157,961** | **44,338** | **0.6%** |

| Actual | Budget | $ Variance | % Variance | Enrollment (by Network) | Actual | Budget | $ Variance | % Variance |
|---|---|---|---|---|---|---|---|---|
| 186,732 | 176,531 | 10,201 | 5.8% | HMO | 1,609,251 | 1,561,549 | 47,702 | 3.1% |
| 224,478 | 229,706 | (5,228) | (2.3%) | PHC | 1,978,510 | 2,023,892 | (45,382) | (2.2%) |
| 197,150 | 198,671 | (1,521) | (0.8%) | Shared Risk Group | 1,703,590 | 1,728,622 | (25,032) | (1.4%) |
| 201,158 | 191,261 | 9,897 | 5.2% | Fee for Service | 1,760,968 | 1,701,433 | 59,535 | 3.5% |
| **809,518** | **796,169** | **13,349** | **1.7%** | **Medi-Cal Total** | **7,052,319** | **7,015,496** | **36,823** | **0.5%** |
| **14,748** | **13,921** | **827** | **5.9%** | **OneCare Connect** | **132,018** | **126,247** | **5,771** | **4.6%** |
| **1,714** | **1,378** | **336** | **24.4%** | **OneCare** | **14,477** | **12,402** | **2,075** | **16.7%** |
| **388** | **451** | **(63)** | **(14.0%)** | **PACE** | **3,485** | **3,816** | **(331)** | **(8.7%)** |
| **826,368** | **811,919** | **14,449** | **1.8%** | **CalOptima Total** | **7,202,299** | **7,157,961** | **44,338** | **0.6%** |

**CalOptima**
**Enrollment Trend by Network**
**Fiscal Year 2021**

| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | YTD Actual | YTD Budget | Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **HMOs** | | | | | | | | | | | | | | | |
| SPD | 10,536 | 10,583 | 10,588 | 10,639 | 10,658 | 10,725 | 11,756 | 9,640 | 10,723 | | | | 95,848 | 93,161 | 2,687 |
| BCCTP | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | 9 | 9 | 0 |
| TANF Child | 54,644 | 55,088 | 55,115 | 55,276 | 55,934 | 56,264 | 56,566 | 56,582 | 56,962 | | | | 502,431 | 524,590 | (22,159) |
| TANF Adult | 29,033 | 29,687 | 30,001 | 30,679 | 30,990 | 31,336 | 31,677 | 31,995 | 32,455 | | | | 277,853 | 264,843 | 13,010 |
| LTC | (1) | 402 | 197 | 215 | 239 | 238 | (1,283) | | | | | | 7 | 18 | (11) |
| MCE | 74,441 | 75,955 | 76,054 | 78,435 | 79,490 | 80,792 | 82,386 | 82,587 | 84,474 | | | | 714,614 | 660,523 | 54,091 |
| WCM | 1,721 | 1,726 | 2,086 | 2,507 | 2,007 | 2,067 | 2,109 | 2,149 | 2,117 | | | | 18,489 | 18,405 | 84 |
| **Total** | **170,375** | **173,442** | **174,042** | **177,752** | **179,319** | **181,423** | **183,212** | **182,954** | **186,732** | | | | **1,609,251** | **1,561,549** | **47,702** |
| **PHCs** | | | | | | | | | | | | | | | |
| SPD | 7,145 | 7,205 | 6,855 | 6,760 | 7,010 | 7,042 | 7,103 | 6,774 | 6,926 | | | | 62,820 | 63,199 | (379) |
| BCCTP | | | | | | | | | | | | | - | | 0 |
| TANF Child | 149,810 | 151,008 | 148,874 | 150,336 | 152,122 | 152,428 | 152,751 | 152,998 | 153,502 | | | | 1,363,829 | 1,435,994 | (72,165) |
| TANF Adult | 11,688 | 12,097 | 12,071 | 12,492 | 12,728 | 12,694 | 12,930 | 13,071 | 13,277 | | | | 113,048 | 105,335 | 7,713 |
| LTC | | 158 | 81 | 65 | 76 | 80 | (456) | | | | | | 4 | 9 | (5) |
| MCE | 39,815 | 40,711 | 39,935 | 41,371 | 41,820 | 42,350 | 42,781 | 42,628 | 43,255 | | | | 374,666 | 354,705 | 19,961 |
| WCM | 5,625 | 5,716 | 7,990 | 8,497 | 6,957 | 7,099 | 7,533 | 7,208 | 7,518 | | | | 64,143 | 64,650 | (507) |
| **Total** | **214,083** | **216,895** | **215,806** | **219,521** | **220,713** | **221,693** | **222,642** | **222,679** | **224,478** | | | | **1,978,510** | **2,023,892** | **(45,382)** |
| **Shared Risk Groups** | | | | | | | | | | | | | | | |
| SPD | 10,264 | 10,312 | 10,068 | 10,117 | 10,120 | 10,261 | 10,927 | 9,519 | 10,229 | | | | 91,817 | 90,638 | 1,179 |
| BCCTP | | | | | | | | | | | | | - | | 0 |
| TANF Child | 58,289 | 58,687 | 57,269 | 58,133 | 58,881 | 58,952 | 59,011 | 58,901 | 58,985 | | | | 527,108 | 585,345 | (58,237) |
| TANF Adult | 28,914 | 29,648 | 29,235 | 30,414 | 30,910 | 31,050 | 31,495 | 31,655 | 32,014 | | | | 275,335 | 268,169 | 7,166 |
| LTC | 1 | 365 | 178 | 209 | 217 | 219 | (1,185) | (1) | | | | | 3 | 18 | (15) |
| MCE | 82,747 | 84,907 | 83,063 | 87,432 | 88,969 | 90,268 | 92,357 | 92,006 | 94,565 | | | | 796,314 | 769,218 | 27,096 |
| WCM | 924 | 1,000 | 1,954 | 2,189 | 1,382 | 1,408 | 1,419 | 1,380 | 1,357 | | | | 13,013 | 15,234 | (2,221) |
| **Total** | **181,139** | **184,919** | **181,767** | **188,494** | **190,479** | **192,158** | **194,024** | **193,460** | **197,150** | | | | **1,703,590** | **1,728,622** | **(25,032)** |
| **Fee for Service (Dual)** | | | | | | | | | | | | | | | |
| SPD | 74,615 | 75,198 | 75,269 | 76,815 | 76,628 | 77,616 | 85,109 | 73,178 | 78,487 | | | | 692,915 | 662,241 | 30,674 |
| BCCTP | 12 | 17 | 18 | 18 | 14 | 14 | 16 | 15 | 18 | | | | 142 | 153 | (11) |
| TANF Child | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | 9 | 22 | (13) |
| TANF Adult | 909 | 1,266 | 994 | 1,107 | 1,015 | 1,030 | 1,064 | 1,119 | 1,173 | | | | 9,677 | 9,002 | 675 |
| LTC | 3,079 | 4,461 | 3,855 | 3,838 | 3,818 | 3,817 | (2,123) | 2,706 | 2,651 | | | | 26,102 | 28,485 | (2,383) |
| MCE | 1,658 | 1,859 | 1,948 | 2,077 | 2,138 | 2,334 | 2,430 | 2,390 | 2,674 | | | | 19,508 | 14,158 | 5,350 |
| WCM | 13 | 17 | 16 | 17 | 15 | 14 | 17 | 15 | 16 | | | | 140 | 117 | 23 |
| **Total** | **80,287** | **82,819** | **82,101** | **83,873** | **83,629** | **84,826** | **86,514** | **79,424** | **85,020** | | | | **748,493** | **714,178** | **34,315** |
| **Fee for Service (Non-Dual - Total)** | | | | | | | | | | | | | | | |
| SPD | 9,830 | 9,822 | 10,264 | 9,977 | 9,304 | 9,774 | 10,737 | 8,838 | 9,978 | | | | 88,524 | 89,170 | (646) |
| BCCTP | 497 | 492 | 499 | 506 | 485 | 490 | 515 | 501 | 496 | | | | 4,481 | 4,142 | 339 |
| TANF Child | 25,494 | 27,007 | 28,092 | 26,150 | 26,005 | 25,664 | 26,404 | 26,451 | 26,129 | | | | 237,396 | 245,464 | (8,068) |
| TANF Adult | 23,028 | 24,014 | 24,847 | 24,196 | 24,229 | 24,315 | 24,823 | 25,042 | 25,187 | | | | 219,681 | 192,008 | 27,673 |
| LTC | 351 | 788 | 580 | 573 | 560 | 580 | (1,237) | 302 | 297 | | | | 2,794 | 3,087 | (293) |
| MCE | 45,498 | 47,292 | 52,445 | 48,625 | 49,046 | 49,527 | 52,810 | 52,979 | 53,128 | | | | 451,350 | 444,404 | 6,946 |
| WCM | 791 | 806 | 974 | 1,076 | 896 | 899 | 1,014 | 870 | 923 | | | | 8,249 | 8,980 | (731) |
| **Total** | **105,489** | **110,221** | **117,701** | **111,103** | **110,525** | **111,249** | **115,066** | **114,983** | **116,138** | | | | **1,012,475** | **987,255** | **25,220** |
| SPD | 112,390 | 113,120 | 113,044 | 114,308 | 113,720 | 115,418 | 125,632 | 107,949 | 116,343 | | | | 1,031,924 | 998,409 | 33,515 |
| BCCTP | 510 | 510 | 518 | 525 | 500 | 505 | 532 | 517 | 515 | | | | 4,632 | 4,304 | 328 |
| TANF Child | 288,238 | 291,791 | 289,351 | 289,896 | 292,943 | 293,309 | 294,733 | 294,933 | 295,579 | | | | 2,630,773 | 2,791,415 | (160,642) |
| TANF Adult | 93,572 | 96,712 | 97,148 | 98,888 | 99,872 | 100,425 | 101,989 | 102,882 | 104,106 | | | | 895,594 | 839,357 | 56,237 |
| LTC | 3,430 | 6,174 | 4,891 | 4,900 | 4,910 | 4,934 | (6,284) | 3,007 | 2,948 | | | | 28,910 | 31,617 | (2,707) |
| MCE | 244,159 | 250,724 | 253,445 | 257,940 | 261,463 | 265,271 | 272,764 | 272,590 | 278,096 | | | | 2,356,452 | 2,243,008 | 113,444 |
| WCM | 9,074 | 9,265 | 13,020 | 14,286 | 11,257 | 11,487 | 12,092 | 11,622 | 11,931 | | | | 104,034 | 107,386 | (3,352) |
| **Total Medi-Cal MM** | **751,373** | **768,296** | **771,417** | **780,743** | **784,665** | **791,349** | **801,458** | **793,500** | **809,518** | | | | **7,052,319** | **7,015,496** | **36,823** |
| **OneCare Connect** | **14,465** | **14,541** | **14,529** | **14,720** | **14,587** | **14,938** | **14,921** | **14,569** | **14,748** | | | | **132,018** | **126,247** | **5,771** |
| **OneCare** | **1,525** | **1,523** | **1,594** | **1,627** | **1,625** | **1,609** | **1,615** | **1,645** | **1,714** | | | | **14,477** | **12,402** | **2,075** |
| **PACE** | **382** | **381** | **380** | **387** | **393** | **394** | **389** | **391** | **388** | | | | **3,485** | **3,816** | **(331)** |
| **Grand Total** | **767,745** | **784,741** | **787,920** | **797,477** | **801,270** | **808,290** | **818,383** | **810,105** | **826,368** | | | | **7,202,299** | **7,157,961** | **44,338** |

## ENROLLMENT:

**Overall,** March enrollment was 826,368

- Favorable to budget 14,449 or 1.8%
- Increased 16,263 or 2.0% from prior month (PM) (February 2021)
- Increased 97,219 or 13.3% from prior year (PY) (March 2020)

**Medi-Cal** enrollment was 809,518

- Favorable to budget 13,349 or 1.7%
    - Medi-Cal Expansion (MCE) favorable 23,167
    - Seniors and Persons with Disabilities (SPD) favorable 5,251
    - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 49
    - Temporary Assistance for Needy Families (TANF) unfavorable 14,543
    - Long-Term Care (LTC) unfavorable 573
    - Whole Child Model (WCM) unfavorable 2
- Increased 16,018 from PM

**OneCare Connect** enrollment was 14,748

- Favorable to budget 827 or 5.9%
- Increased 179 from PM

**OneCare** enrollment was 1,714

- Favorable to budget 336 or 24.4%
- Increased 69 from PM

**PACE** enrollment was 388

- Unfavorable to budget 63 or 14.0%
- Decreased 3 from PM

# CalOptima
## Medi-Cal Total
## Statement of Revenues and Expenses
## For the Nine Months Ending March 31, 2021

| Month Actual | Month Budget | Month $ Variance | Month % Variance | | YTD Actual | YTD Budget | YTD $ Variance | YTD % Variance |
|---|---|---|---|---|---|---|---|---|
| **809,518** | **796,169** | **13,349** | **1.7%** | **Member Months** | **7,052,319** | **7,015,496** | **36,823** | **0.5%** |
| | | | | **Revenues** | | | | |
| 388,968,671 | 240,091,608 | 148,877,063 | 62.0% | Capitation Revenue | 2,730,137,566 | 2,464,015,804 | 266,121,762 | 10.8% |
| **388,968,671** | **240,091,608** | **148,877,063** | **62.0%** | **Total Operating Revenue** | **2,730,137,566** | **2,464,015,804** | **266,121,762** | **10.8%** |
| | | | | **Medical Expenses** | | | | |
| 101,013,456 | 96,543,219 | (4,470,237) | (4.6%) | Provider Capitation | 866,401,870 | 878,170,322 | 11,768,452 | 1.3% |
| 56,848,284 | 61,069,736 | 4,221,452 | 6.9% | Facilities Claims | 458,961,300 | 525,758,713 | 66,797,413 | 12.7% |
| 32,366,903 | 34,365,448 | 1,998,545 | 5.8% | Professional Claims | 270,477,601 | 297,002,413 | 26,524,812 | 8.9% |
| 57,294,163 | - | (57,294,163) | 0.0% | Prescription Drugs | 457,320,784 | 280,984,863 | (176,335,921) | (62.8%) |
| 39,512,359 | 41,260,657 | 1,748,298 | 4.2% | MLTSS | 344,389,184 | 361,701,677 | 17,312,493 | 4.8% |
| 4,715,327 | 5,058,044 | 342,717 | 6.8% | Medical Management | 36,597,575 | 43,810,003 | 7,212,428 | 16.5% |
| 91,135,502 | 604,009 | (90,531,493) | (14988.4%) | Reinsurance & Other | 198,761,536 | 5,436,063 | (193,325,473) | (3556.4%) |
| **382,885,995** | **238,901,113** | **(143,984,882)** | **(60.3%)** | **Total Medical Expenses** | **2,632,909,851** | **2,392,864,054** | **(240,045,797)** | **(10.0%)** |
| **6,082,676** | **1,190,495** | **4,892,181** | **410.9%** | **Gross Margin** | **97,227,715** | **71,151,750** | **26,075,965** | **36.6%** |
| | | | | **Administrative Expenses** | | | | |
| 7,258,589 | 7,519,237 | 260,648 | 3.5% | Salaries, Wages & Employee Benefits | 61,440,393 | 62,505,359 | 1,064,966 | 1.7% |
| 81,663 | 320,521 | 238,858 | 74.5% | Professional Fees | 1,107,446 | 2,847,549 | 1,740,103 | 61.1% |
| 836,020 | 933,513 | 97,493 | 10.4% | Purchased Services | 7,266,952 | 9,666,868 | 2,399,916 | 24.8% |
| 250,116 | 509,058 | 258,942 | 50.9% | Printing and Postage | 2,101,128 | 4,056,522 | 1,955,394 | 48.2% |
| 602,034 | 458,500 | (143,534) | (31.3%) | Depreciation & Amortization | 2,905,683 | 4,126,500 | 1,220,817 | 29.6% |
| 1,225,922 | 1,678,434 | 452,512 | 27.0% | Other Operating Expenses | 12,344,768 | 15,083,607 | 2,738,839 | 18.2% |
| 1,219,834 | 1,670,449 | 450,615 | 27.0% | MC Other operating expenses | 12,293,018 | 15,011,742 | 2,718,724 | 18.1% |
| 6,088 | 7,985 | 1,897 | 23.8% | MSSP Other operating expenses | 51,751 | 71,865 | 20,114 | 28.0% |
| (195,929) | (214,763) | (18,834) | (8.8%) | Indirect Cost Allocation, Occupancy Expense | (2,531,441) | (1,894,572) | 636,869 | 33.6% |
| **10,058,415** | **11,204,500** | **1,146,085** | **10.2%** | **Total Administrative Expenses** | **84,634,928** | **96,391,833** | **11,756,905** | **12.2%** |
| | | | | **Operating Tax** | | | | |
| 13,632,041 | 15,410,472 | (1,778,431) | (11.5%) | Tax Revenue | 112,878,244 | 135,833,320 | (22,955,076) | (16.9%) |
| 12,468,750 | 15,410,472 | 2,941,722 | 19.1% | Premium Tax Expense | 112,218,750 | 135,833,320 | 23,614,570 | 17.4% |
| - | - | - | 0.0% | Sales Tax Expense | - | - | - | 0.0% |
| 1,163,291 | (0) | 1,163,291 | **0.0%** | **Total Net Operating Tax** | 659,494 | - | 659,494 | **0.0%** |
| | | | | **Grant Income** | | | | |
| 15,509 | - | 15,509 | 0.0% | Grant Revenue | 279,664 | - | 279,664 | 0.0% |
| - | - | - | 0.0% | Grant expense - Service Partner | 201,238 | - | (201,238) | 0.0% |
| 15,509 | - | (15,509) | 0.0% | Grant expense - Administrative | 64,376 | - | (64,376) | 0.0% |
| - | - | - | **0.0%** | **Total Grant Income** | 14,050 | - | 14,050 | **0.0%** |
| **505** | **-** | **505** | **0.0%** | **Other income** | **835** | **-** | **835** | **0.0%** |
| **(2,811,943)** | **(10,014,005)** | **7,202,062** | **71.9%** | **Change in Net Assets** | **13,267,166** | **(25,240,083)** | **38,507,249** | **152.6%** |
| ***98.4%*** | ***99.5%*** | ***1.1%*** | ***1.1%*** | ***Medical Loss Ratio*** | ***96.4%*** | ***97.1%*** | ***0.7%*** | ***0.7%*** |
| ***2.6%*** | ***4.7%*** | ***2.1%*** | ***44.6%*** | ***Admin Loss Ratio*** | ***3.1%*** | ***3.9%*** | ***0.8%*** | ***20.8%*** |

## MEDI-CAL INCOME STATEMENT– MARCH MONTH:

**REVENUES** of $389.0 million are favorable to budget $148.9 million driven by:

- Favorable volume related variance of $4.0 million
- Favorable price related variance of $144.9 million
  - $91.7 million of fiscal year (FY) 2019 hospital Directed Payments (DP)
  - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
  - Offset by $5.1 million of Proposition 56 risk corridor reserve

**MEDICAL EXPENSES** of $382.9 million are unfavorable to budget $144.0 million driven by:

- Unfavorable volume related variance of $4.0 million
- Unfavorable price related variance of $140.0 million
  - Reinsurance & Other expense unfavorable variance of $90.5 million due to FY 2019 DP
  - Prescription Drugs expense unfavorable variance of $57.3 million due to DHCS postponing pharmacy benefit transition to FFS
  - Provider Capitation expense unfavorable variance of $2.9 million
  - Offset by Facilities Claims expense favorable variance of $5.2 million
  - Professional Claims expense favorable variance of $2.6 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $2.4 million

**ADMINISTRATIVE EXPENSES** of $10.1 million are favorable to budget $1.1 million driven by:

- Other Non-Salary expense favorable to budget $1.3 million
- Salaries & Benefit expense favorable to budget $0.3 million

**CHANGE IN NET ASSETS** is ($2.8) million for the month, favorable to budget $7.2 million

# CalOptima
## OneCare Connect Total
## Statement of Revenue and Expenses
## For the Nine Months Ending March 31, 2021

| Month Actual | Month Budget | Month $ Variance | Month % Variance | | YTD Actual | YTD Budget | YTD $ Variance | YTD % Variance |
|---|---|---|---|---|---|---|---|---|
| **14,748** | **13,921** | **827** | **5.9%** | **Member Months** | **132,018** | **126,247** | **5,771** | **4.6%** |
| | | | | Revenues | | | | |
| 3,072,009 | 2,687,084 | 384,925 | 14.3% | Medi-Cal Capitation Revenue | 26,541,323 | 24,371,472 | 2,169,851 | 8.9% |
| 22,345,044 | 17,455,320 | 4,889,724 | 28.0% | Medicare Capitation Revenue Part C | 180,118,982 | 159,869,216 | 20,249,766 | 12.7% |
| 6,000,194 | 5,045,617 | 954,577 | 18.9% | Medicare Capitation Revenue Part D | 50,566,244 | 46,462,730 | 4,103,514 | 8.8% |
| **31,417,247** | **25,188,021** | **6,229,226** | **24.7%** | **Total Operating Revenue** | **257,226,549** | **230,703,418** | **26,523,131** | **11.5%** |
| | | | | **Medical Expenses** | | | | |
| 14,113,389 | 10,665,959 | (3,447,430) | (32.3%) | Provider Capitation | 112,054,859 | 100,540,133 | (11,514,726) | (11.5%) |
| 5,391,331 | 3,989,966 | (1,401,365) | (35.1%) | Facilities Claims | 45,120,485 | 35,845,864 | (9,274,621) | (25.9%) |
| 1,060,808 | 976,016 | (84,792) | (8.7%) | Ancillary | 8,904,997 | 8,466,971 | (438,026) | (5.2%) |
| 1,294,626 | 1,524,676 | 230,050 | 15.1% | MLTSS | 12,570,172 | 13,709,021 | 1,138,849 | 8.3% |
| 6,613,157 | 6,057,870 | (555,287) | (9.2%) | Prescription Drugs | 53,744,288 | 52,912,127 | (832,161) | (1.6%) |
| 1,107,205 | 1,276,944 | 169,739 | 13.3% | Medical Management | 9,750,464 | 10,723,661 | 973,197 | 9.1% |
| 90,501 | 228,430 | 137,929 | 60.4% | Other Medical Expenses | 1,187,283 | 1,961,318 | 774,035 | 39.5% |
| **29,671,017** | **24,719,861** | **(4,951,156)** | **(20.0%)** | **Total Medical Expenses** | **243,332,548** | **224,159,095** | **(19,173,453)** | **(8.6%)** |
| **1,746,230** | **468,160** | **1,278,070** | **273.0%** | **Gross Margin** | **13,894,001** | **6,544,323** | **7,349,678** | **112.3%** |
| | | | | **Administrative Expenses** | | | | |
| 724,424 | 860,759 | 136,335 | 15.8% | Salaries, Wages & Employee Benefits | 6,298,338 | 7,139,664 | 841,326 | 11.8% |
| 5,333 | 40,083 | 34,750 | 86.7% | Professional Fees | 154,363 | 360,747 | 206,384 | 57.2% |
| 153,767 | 103,412 | (50,355) | (48.7%) | Purchased Services | 799,920 | 930,708 | 130,788 | 14.1% |
| 87,137 | 106,517 | 19,380 | 18.2% | Printing and Postage | 724,409 | 958,653 | 234,244 | 24.4% |
| (301) | 15,861 | 16,162 | 101.9% | Other Operating Expenses | 258,561 | 145,731 | (112,830) | (77.4%) |
| 480,751 | 553,492 | 72,741 | 13.1% | Indirect Cost Allocation | 5,273,988 | 4,981,428 | (292,560) | (5.9%) |
| **1,451,111** | **1,680,124** | **229,013** | **13.6%** | **Total Administrative Expenses** | **13,509,579** | **14,516,931** | **1,007,352** | **6.9%** |
| **295,119** | **(1,211,964)** | **1,507,083** | **124.4%** | **Change in Net Assets** | **384,422** | **(7,972,608)** | **8,357,030** | **104.8%** |
| ***94.4%*** | ***98.1%*** | ***3.7%*** | ***3.8%*** | ***Medical Loss Ratio*** | ***94.6%*** | ***97.2%*** | ***2.6%*** | ***2.6%*** |
| ***4.6%*** | ***6.7%*** | ***2.1%*** | ***30.8%*** | ***Admin Loss Ratio*** | ***5.3%*** | ***6.3%*** | ***1.0%*** | ***16.5%*** |

## ONECARE CONNECT INCOME STATEMENT– MARCH MONTH:

**REVENUES** of $31.4 million are favorable to budget $6.2 million driven by:

- Favorable volume related variance of $1.5 million
- Favorable price related variance of $4.7 million due to Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2021 and CY 2020 final Hierarchical Condition Category (HCC) reconciliation

**MEDICAL EXPENSES** of $29.7 million are unfavorable to budget $5.0 million driven by:

- Unfavorable volume related variance of $1.5 million
- Unfavorable price related variance of $3.5 million
    - Provider Capitation expense unfavorable variance of $2.8 million
    - Facilities Claims expense unfavorable variance of $1.2 million

**ADMINISTRATIVE EXPENSES** of $1.5 million are favorable to budget $0.2 million

**CHANGE IN NET ASSETS** is $0.3 million, favorable to budget $1.5 million

# CalOptima
# OneCare
## Statement of Revenues and Expenses
## For the Nine Months Ending March 31, 2021

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **1,714** | **1,378** | **336** | **24.4%** | **Member Months** | **14,477** | **12,402** | **2,075** | **16.7%** |
| | | | | **Revenues** | | | | |
| 1,642,126 | 1,070,368 | 571,758 | 53.4% | Medicare Part C revenue | 12,657,553 | 10,112,670 | 2,544,883 | 25.2% |
| 626,783 | 485,702 | 141,081 | 29.0% | Medicare Part D revenue | 5,531,584 | 4,680,907 | 850,677 | 18.2% |
| **2,268,909** | **1,556,070** | **712,839** | **45.8%** | **Total Operating Revenue** | **18,189,137** | **14,793,577** | **3,395,560** | **23.0%** |
| | | | | **Medical Expenses** | | | | |
| 635,867 | 423,082 | (212,785) | (50.3%) | Provider Capitation | 5,018,111 | 3,941,725 | (1,076,386) | (27.3%) |
| 984,353 | 444,139 | (540,214) | (121.6%) | Inpatient | 5,185,547 | 4,045,942 | (1,139,605) | (28.2%) |
| 46,600 | 43,881 | (2,719) | (6.2%) | Ancillary | 637,869 | 386,690 | (251,179) | (65.0%) |
| 22,654 | 25,895 | 3,242 | 12.5% | Skilled Nursing Facilities | 264,224 | 228,877 | (35,347) | (15.4%) |
| 663,407 | 507,919 | (155,488) | (30.6%) | Prescription Drugs | 5,354,411 | 4,395,812 | (958,599) | (21.8%) |
| 35,926 | 45,766 | 9,840 | 21.5% | Medical Management | 326,502 | 391,418 | 64,916 | 16.6% |
| 25 | 152 | 127 | 83.6% | Other Medical Expenses | 25 | 455 | 430 | 94.5% |
| **2,388,832** | **1,490,834** | **(897,998)** | **(60.2%)** | **Total Medical Expenses** | **16,786,688** | **13,390,919** | **(3,395,769)** | **(25.4%)** |
| **(119,923)** | **65,236** | **(185,159)** | **(283.8%)** | **Gross Margin** | **1,402,448** | **1,402,658** | **(210)** | **(0.0%)** |
| | | | | **Administrative Expenses** | | | | |
| 85,412 | 71,148 | (14,264) | (20.0%) | Salaries, wages & employee benefits | 745,617 | 606,052 | (139,565) | (23.0%) |
| 16,000 | 16,000 | - | 0.0% | Professional fees | 156,973 | 144,000 | (12,973) | (9.0%) |
| 9,430 | 9,750 | 320 | 3.3% | Purchased services | 74,629 | 87,750 | 13,121 | 15.0% |
| 3,763 | 8,084 | 4,321 | 53.5% | Printing and postage | 50,412 | 72,756 | 22,344 | 30.7% |
| 448 | 537 | 89 | 16.6% | Other operating expenses | 653 | 4,833 | 4,180 | 86.5% |
| 35,551 | 35,185 | (366) | (1.0%) | Indirect cost allocation, occupancy expense | 372,937 | 316,665 | (56,272) | (17.8%) |
| **150,604** | **140,704** | **(9,900)** | **(7.0%)** | **Total Administrative Expenses** | **1,401,221** | **1,232,056** | **(169,165)** | **(13.7%)** |
| **(270,527)** | **(75,468)** | **(195,059)** | **(258.5%)** | **Change in Net Assets** | **1,227** | **170,602** | **(169,375)** | **(99.3%)** |
| ***105.3%*** | ***95.8%*** | ***(9.5%)*** | ***(9.9%)*** | ***Medical Loss Ratio*** | ***92.3%*** | ***90.5%*** | ***(1.8%)*** | ***(2.0%)*** |
| ***6.6%*** | ***9.0%*** | ***2.4%*** | ***26.6%*** | ***Admin Loss Ratio*** | ***7.7%*** | ***8.3%*** | ***0.6%*** | ***7.5%*** |

# CalOptima
# PACE
## Statement of Revenues and Expenses
## For the Nine Months Ending March 31, 2021

| Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance | % Variance | | Actual | Budget | $ Variance | % Variance |
| **388** | **451** | **(63)** | **(14.0%)** | **Member Months** | **3,485** | **3,816** | **(331)** | **-8.7%** |
| | | | | **Revenues** | | | | |
| 2,443,115 | 2,840,185 | (397,070) | (14.0%) | Medi-Cal Capitation Revenue | 21,943,118 | 24,025,576 | (2,082,458) | (8.7%) |
| 535,662 | 641,702 | (106,040) | (16.5%) | Medicare Part C Revenue | 5,705,257 | 5,560,384 | 144,873 | 2.6% |
| 154,098 | 158,600 | (4,502) | (2.8%) | Medicare Part D Revenue | 1,510,356 | 1,352,685 | 157,671 | 11.7% |
| **3,132,874** | **3,640,487** | **(507,613)** | **(13.9%)** | **Total Operating Revenue** | **29,158,730** | **30,938,645** | **(1,779,915)** | **(5.8%)** |
| | | | | **Medical Expenses** | | | | |
| 925,548 | 1,061,156 | 135,608 | 12.8% | Medical Management | 7,728,615 | 8,731,193 | 1,002,578 | 11.5% |
| 1,488,451 | 905,170 | (583,281) | (64.4%) | Facilities Claims | 6,748,173 | 7,309,557 | 561,384 | 7.7% |
| 947,943 | 741,330 | (206,613) | (27.9%) | Professional Claims | 5,761,223 | 6,089,280 | 328,057 | 5.4% |
| 179,742 | 283,439 | 103,697 | 36.6% | Patient Transportation | 1,027,810 | 2,313,155 | 1,285,345 | 55.6% |
| 304,095 | 304,184 | 89 | 0.0% | Prescription Drugs | 2,572,685 | 2,501,903 | (70,782) | (2.8%) |
| 84,337 | 76,056 | (8,281) | (10.9%) | MLTSS | 572,431 | 587,879 | 15,448 | 2.6% |
| 4,850 | 20,288 | 15,438 | 76.1% | Other Expenses | 127,922 | 168,518 | 40,597 | 24.1% |
| **3,934,967** | **3,391,623** | **(543,344)** | **(16.0%)** | **Total Medical Expenses** | **24,538,859** | **27,701,485** | **3,162,626** | **11.4%** |
| **(802,092)** | **248,864** | **(1,050,956)** | **-422.3%** | **Gross Margin** | **4,619,871** | **3,237,160** | **1,382,711** | **42.7%** |
| | | | | **Administrative Expenses** | | | | |
| 107,360 | 139,633 | 32,273 | 23.1% | Salaries, wages & employee benefits | 1,035,221 | 1,126,528 | 91,307 | 8.1% |
| 123 | 166 | 43 | 25.7% | Professional fees | 1,150 | 1,494 | 344 | 23.0% |
| 5,207 | 39,651 | 34,444 | 86.9% | Purchased services | 134,044 | 269,359 | 135,315 | 50.2% |
| 18,280 | 17,325 | (955) | (5.5%) | Printing and postage | 115,760 | 133,425 | 17,665 | 13.2% |
| 2,013 | 2,070 | 57 | 2.8% | Depreciation & amortization | 18,233 | 18,630 | 397 | 2.1% |
| 5,449 | 4,536 | (913) | (20.1%) | Other operating expenses | 42,575 | 37,012 | (5,563) | (15.0%) |
| 1,683 | 4,709 | 3,026 | 64.3% | Indirect Cost Allocation, Occupancy Expense | 32,843 | 40,858 | 8,015 | 19.6% |
| **140,116** | **208,090** | **67,974** | **32.7%** | **Total Administrative Expenses** | **1,379,827** | **1,627,306** | **247,479** | **15.2%** |
| | | | | **Operating Tax** | | | | |
| 5,758 | - | 5,758 | 0.0% | Tax Revenue | 51,717 | - | 51,717 | 0.0% |
| 5,758 | - | (5,758) | 0.0% | Premium Tax Expense | 51,717 | - | (51,717) | 0.0% |
| **-** | **-** | **-** | **0.0%** | **Total Net Operating Tax** | **-** | **-** | **-** | **0.0%** |
| **(942,208)** | **40,774** | **(982,982)** | **(2410.8%)** | **Change in Net Assets** | **3,240,045** | **1,609,854** | **1,630,191** | **101.3%** |
| ***125.6%*** | ***93.2%*** | ***(32.4%)*** | ***(34.8%)*** | ***Medical Loss Ratio*** | ***84.2%*** | ***89.5%*** | ***5.4%*** | ***6.0%*** |
| ***4.5%*** | ***5.7%*** | ***1.2%*** | ***21.8%*** | ***Admin Loss Ratio*** | ***4.7%*** | ***5.3%*** | ***0.5%*** | ***10.0%*** |

# CalOptima
## Building 505 - City Parkway
## Statement of Revenues and Expenses
## For the Nine Months Ending March 31, 2021

| Month Actual | Month Budget | Month $ Variance | Month % Variance | | YTD Actual | YTD Budget | YTD $ Variance | YTD % Variance |
|---|---|---|---|---|---|---|---|---|
| | | | | **Revenues** | | | | |
| - | - | - | 0.0% | Rental Income | - | - | - | 0.0% |
| **-** | **-** | **-** | **0.0%** | **Total Operating Revenue** | **-** | **-** | **-** | **0.0%** |
| | | | | **Administrative Expenses** | | | | |
| 36,691 | 55,000 | 18,309 | 33.3% | Purchase services | 346,616 | 495,000 | 148,384 | 30.0% |
| 168,341 | 177,250 | 8,909 | 5.0% | Depreciation & amortization | 1,530,889 | 1,595,250 | 64,361 | 4.0% |
| 18,423 | 18,500 | 77 | 0.4% | Insurance expense | 165,804 | 166,500 | 696 | 0.4% |
| 101,117 | 114,916 | 13,799 | 12.0% | Repair and maintenance | 944,704 | 1,034,250 | 89,546 | 8.7% |
| 32,304 | 41,250 | 8,946 | 21.7% | Other Operating Expense | 416,938 | 371,250 | (45,688) | (12.3%) |
| (356,876) | (406,916) | (50,040) | (12.3%) | Indirect allocation, Occupancy | (3,404,951) | (3,662,250) | (257,299) | (7.0%) |
| **-** | **-** | **-** | **0.0%** | **Total Administrative Expenses** | **-** | **-** | **-** | **0.0%** |
| **-** | **-** | **-** | **0.0%** | **Change in Net Assets** | **-** | **-** | **-** | **0.0%** |

## OTHER INCOME STATEMENTS – MARCH MONTH:

## ONECARE INCOME STATEMENT

**CHANGE IN NET ASSETS** is ($0.3) million, unfavorable to budget $0.2 million

## PACE INCOME STATEMENT

**CHANGE IN NET ASSETS** is ($0.9) million, unfavorable to budget $1.0 million

# CalOptima
# Balance Sheet
# March 31, 2021

**ASSETS**

| | |
|---|---|
| Current Assets | |
| Operating Cash | $416,486,933 |
| Investments | 933,965,135 |
| Capitation receivable | 322,713,706 |
| Receivables - Other | 45,590,643 |
| Prepaid expenses | 8,174,739 |
| **Total Current Assets** | **1,726,931,156** |
| Capital Assets | |
| Furniture & Equipment | 46,910,603 |
| Building/Leasehold Improvements | 5,388,527 |
| 505 City Parkway West | 51,646,314 |
| | 103,945,443 |
| Less: accumulated depreciation | (58,186,289) |
| Capital assets, net | 45,759,154 |
| Other Assets | |
| Restricted Deposit & Other | 300,000 |
| Homeless Health Reserve | 56,798,913 |
| Board-designated assets: | |
| Cash and Cash Equivalents | 1,274,715 |
| Long-term Investments | 586,802,263 |
| Total Board-designated Assets | 588,076,978 |
| **Total Other Assets** | 645,175,891 |
| **TOTAL ASSETS** | **2,417,866,201** |
| Deferred Outflows | |
| Contributions | 1,047,297 |
| Difference in Experience | 4,280,308 |
| Excess Earning | - |
| Changes in Assumptions | 5,060,465 |
| OPEB 75 Changes in Assumptions | 703,000 |
| Pension Contributions | 570,000 |
| **TOTAL ASSETS & DEFERRED OUTFLOWS** | **2,429,527,271** |

**LIABILITIES & NET POSITION**

| | |
|---|---|
| Current Liabilities | |
| Accounts Payable | $45,422,050 |
| Medical Claims liability | 1,108,232,503 |
| Accrued Payroll Liabilities | 17,748,731 |
| Deferred Revenue | 17,295,401 |
| Deferred Lease Obligations | 135,860 |
| Capitation and Withholds | 133,732,561 |
| **Total Current Liabilities** | **1,322,567,107** |
| Other (than pensions) post employment benefits liability | 26,212,000 |
| Net Pension Liabilities | 27,354,284 |
| Bldg 505 Development Rights | - |
| **TOTAL LIABILITIES** | **1,376,133,391** |
| Deferred Inflows | |
| Excess Earnings | 506,547 |
| OPEB 75 Difference in Experience | 804,000 |
| Change in Assumptions | 3,728,725 |
| OPEB Changes in Assumptions | 1,638,000 |
| Net Position | |
| TNE | 103,809,007 |
| Funds in Excess of TNE | 942,907,601 |
| **TOTAL NET POSITION** | 1,046,716,608 |
| **TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION** | **2,429,527,271** |

# CalOptima
## Board Designated Reserve and TNE Analysis
## as of March 31, 2021

| Type | Reserve Name | Market Value | Benchmark | | Variance | |
|---|---|---|---|---|---|---|
| | | | Low | High | Mkt - Low | Mkt - High |
| | Tier 1 - Payden & Rygel | 160,891,432 | | | | |
| | Tier 1 - MetLife | 159,855,745 | | | | |
| | Tier 1 - Wells Capital | 160,050,415 | | | | |
| Board-designated Reserve | | | | | | |
| | | 480,797,591 | 329,418,600 | 515,087,574 | 151,378,991 | (34,289,983) |
| TNE Requirement | Tier 2 - MetLife | 107,279,387 | 103,809,007 | 103,809,007 | 3,470,380 | 3,470,380 |
| | **Consolidated:** | **588,076,978** | **433,227,607** | **618,896,581** | **154,849,371** | **(30,819,603)** |
| | *Current reserve level* | *1.90* | *1.40* | *2.00* | | |

**CalOptima**

**Statement of Cash Flows**

**March 31, 2021**

| | **Month Ended** | **Year-To-Date** |
|---|---|---|
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Change in net assets | (4,151,980) | 21,585,311 |
| Adjustments to reconcile change in net assets | | |
| to net cash provided by operating activities | | |
| Depreciation and amortization | 772,388 | 4,454,805 |
| Changes in assets and liabilities: | | |
| Prepaid expenses and other | 863,997 | (1,475,530) |
| Catastrophic reserves | | |
| Capitation receivable | 54,011,904 | 78,065,676 |
| Medical claims liability | 103,344,067 | 191,080,483 |
| Deferred revenue | (352,546) | (6,128,295) |
| Payable to health networks | (4,753,132) | (9,248,467) |
| Accounts payable | 12,611,481 | (29,234,396) |
| Accrued payroll | 1,903,530 | 4,746,264 |
| Other accrued liabilities | (2,822) | (24,997) |
| Net cash provided by/(used in) operating activities | 164,246,889 | 253,820,854 |
| GASB 68 CalPERS Adjustments | - | - |
| CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES: | | |
| Net Asset transfer from Foundation | - | - |
| Net cash provided by (used in) in capital and related financing activities | - | - |
| CASH FLOWS FROM INVESTING ACTIVITIES | | |
| Change in Investments | (27,359,480) | (209,778,823) |
| Change in Property and Equipment | 29,978 | (3,559,388) |
| Change in Board designated reserves | 348,640 | (3,193,085) |
| Change in Homeless Health Reserve | - | 400,000 |
| Net cash provided by/(used in) investing activities | (26,980,862) | (216,131,295) |
| NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS | 137,266,027 | 37,689,559 |
| CASH AND CASH EQUIVALENTS, beginning of period | $279,220,906 | 378,797,374 |
| **CASH AND CASH EQUIVALENTS, end of period** | **416,486,933** | **416,486,933** |

## BALANCE SHEET – MARCH MONTH:

**ASSETS** of $2.4 billion increased $108.6 million from February or 4.7%

- Operating Cash increased $137.3 million due to timing of cash transactions and receipt of FY 2019 DP. Subsequent disbursement of DP scheduled for April 2021
- Investments increased $27.4 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables decreased $55.8 million due to the timing of cash receipts and disbursements

**LIABILITIES** of $1.4 billion increased $112.8 million from February or 8.9%

- Claims Liabilities increased $103.3 million due to FY 2019 DP. Payment scheduled for April 2021
- Accounts Payable increased $12.6 million due to the timing of quarterly premium tax

**NET ASSETS** of $1.0 billion, decreased $4.2 million from February or 0.4%

# Summary of Homeless Health Initiatives and Allocated Funds
# As of March 31, 2021

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

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

This report only lists Board approved projects.

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

**Budget Allocation Changes**
**Reporting Changes for March 2021**

| Transfer Month | Line of Business | From | To | Amount | Expense Description | Fiscal Year |
|---|---|---|---|---|---|---|
| July | Medi-Cal | Maintenance HW/SW – Corporate Application SW - LexisNexis | Maintenance HW/SW – HR Corporate Application SW - SilkRoad | $12,000 | To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses | 2021 |
| October | Medi-Cal | Maintenance HW/SW - UPS Maintenance | Maintenance HW/SW - Desktop - Adobe Acrobat | $35,000 | To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat | 2021 |
| October | Medi-Cal | Maintenance HW/SW - Microsoft True-Up | Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement | $91,000 | To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement | 2021 |
| November | Medi-Cal | Business Integration - Temporary Help | Process Excellence - Temporary Help | $43,000 | To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst. | 2021 |
| January | Medi-Cal | Provider Relations - Printing | Sales & Marketing - Member Communication | $10,000 | To reallocate funds from Public Relations - Printing to cover shortage in Sales & Marketing - Member Communications. | 2021 |
| February | Medi-Cal | Human Resources - Food Service Supply | Human Resources - Cert./Cont. Education | $20,000 | To reallocate funds from Food Service Supply to Cert./Cont. Education to fund the education reimbursement program. | 2021 |
| February | Medi-Cal | Purchase Services - HPA Robot Process | Purchase Services - Burgess Group - Facilities Claims Quarterly | $63,000 | To repurpose funds from HPA Robot Process to Burgess Group to cover shortfall in quarterly facilities claims fee. | 2021 |
| March | Medi-Cal | Employee Learning Management System Network - MDF Switch Upgrade Electronic Health Record System | Provider Portal Communication | $99,500 | To reallocate funds from capital projects Employee Learning Management System, MDF Switch Upgrade and Electronic Health Record System to pay for TekSystems invoices | 2021 |

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

# Board of Directors' Meeting
# May 6, 2021

# Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- 2021 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2021. The validation audit is expected to take place starting in March and conclude in June 2021. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

  The webinar validation took place on April 6, 2021. Following the webinar validation, Advent is expected to request sample selections for each of the reporting measures. CalOptima is working to collect the documents requested for submission ahead of the deadline.

- Contract Year (CY) 2019 Medicare Part D Improper Payment Measure (Part D IPM) (OneCare and OneCare Connect):

  On January 15, 2021, CMS informed CalOptima that its OneCare and OneCare Connect contracts have been selected to participate in the CY 2019 Medicare Part D Improper

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Payment Measure (Part D IPM) audit, formerly known as the Payment Error Related to Prescription Drug Event Validation (PEPV). CMS conducts the Part D IPM audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2019 payments.

On January 29, 2021, CMS informed CalOptima that it had selected two (2) PDEs for review --- one for OneCare and one for OneCare Connect. On March 9, 2021, CalOptima took advantage of the early submission window and submitted documentation for both sample selections to CMS. On March 12, 2021, CMS informed CalOptima that the sample for OneCare "passed" the element check. Element check results for OneCare Connect are still pending.

- Calendar Year (CY) 2015 Medicare Part C National Risk Adjustment Data Validation (CON15 RADV) Audit:

  By way of background, on November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit.

  After suspending audit activities on March 30, 2020, due to the public health emergency, CMS resumed audit activities on September 14, 2020. The submission window closes on April 23, 2021. CalOptima is continuing to submit documents.

2. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare plan sponsors are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

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

  On April 1, 2021, Myers & Stauffer notified CalOptima they have provided a new documentation request list and will be conducting two sets of interviews during the week of April 12, 2021. CalOptima is currently working on the document request and preparing impacted stakeholders to participate in the interviews. The exit conference has been tentatively scheduled for June 18, 2021.


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

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B. Regulatory Notices of Non-Compliance

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

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of December 2020 – February 2021 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for six (6) consecutive months for Medi-Cal expedited appeals and for six (6) consecutive months for Medi-Cal standard appeals.

| Month | Compliance Goal | Expedited Appeals Resolved within ≤ 72 Hours of Receipt |
|---|---|---|
| December 2020 | 98% | 50% |
| January 2021 | 98% | 100% |
| February 2021 | 98% | 100% |

| Month | Compliance Goal | Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt |
|---|---|---|
| December 2020 | 98% | 78% |
| January 2021 | 98% | 61% |
| February 2021 | 98% | 77% |

➢ CalOptima's Audit & Oversight (A&O) department escalated the corrective action plan (CAP) that was previously issued to an immediate corrective action plan (ICAP), as issues with non-timely processing of Medi-Cal appeals have extended to both expedited and standard appeals, appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard and expedited appeals. In addition, CalOptima's Audit & Oversight department has increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities.



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

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

- Medi-Cal GARS: Standard Appeals

| Month(s) | Classification Score | Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Appeals within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 0% | 6.25% |
| February 2021 | 100% | 100% | 100% | 72.22% | 11.76% |

- Based on a focused review of seventeen (17) Medi-Cal standard appeals for February 2021, the lower compliance score of 72.22% was due to five (5) files exceeding the sixth (6th) grade reading level.

- Based on a focused review of seventeen (17) Medi-Cal standard appeals for February 2021, the lower compliance score of 11.76% was due to untimely resolution of fifteen (15) standard appeals.

- Medi-Cal GARS: Expedited Appeals

| Month(s) | Classification Score | Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt | Language Preference | Member Notice Content | Resolution of Expedited Appeals within 72 Hours of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 0% | 100% |
| February 2021 | 100% | 100% | 100% | 66.7% | 100% |

- Based on a focused review of three (3) Medi-Cal expedited appeals for February 2021, the lower compliance score of 66.7% was due to one (1) file exceeding the sixth (6th) grade reading level.



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

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- Medi-Cal GARS: Standard Grievances

| Month(s) | Classification Score | Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 94.4% | 77.8% | 77.8% |
| February 2021 | 100% | 100% | 95% | 70% | 90% |

➢ Based on a focused review of fifteen (15) Medi-Cal standard grievances for February 2021, the lower compliance score of 95% was due to one (1) member notice not being sent in the member's preferred language.

➢ Based on a focused review of fifteen (15) Medi-Cal standard grievances for February 2021, the lower compliance score of 70% was due to incomplete resolution of six (6) grievances.

➢ Based on a focused review of fifteen (15) Medi-Cal standard grievances for February 2021, the lower compliance score of 90% was due to untimely resolution of one (1) grievance.

- Medi-Cal GARS: Expedited Grievances

| Month(s) | Classification Score | Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt | Language Preference | Member Notice Content | Expedited Grievances Resolved within ≤ 72 Hours of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 50% | 100% | 50% |
| February 2021 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |

➢ No significant trends to report in February 2021.


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

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- Medi-Cal Utilization Management: Standard Prior Authorizations

| Month(s) | File Classification | Resolution Timeliness | Provider and Member Notification Timeliness | Clinical Decision Making Review | Processing Accuracy | Written Response in Member's Preferred Language | Accuracy of Member Notice Content |
|---|---|---|---|---|---|---|---|
| December 2020 | 90.9% | 90.9% | 100% | 90.9% | 90.9% | 100% | 100% |
| January 2021 | 100% | 86% | 93% | 93% | 93% | 100% | 93% |
| February 2021 | 100% | 90% | 60% | 100% | 100% | 100% | 80% |

➢ Based on a focused review of ten (10) Medi-Cal standard prior authorizations for February 2021, the lower compliance score of 90% was due to untimely processing of one (1) standard prior authorization.

➢ Based on a focused review of ten (10) Medi-Cal standard prior authorizations for February 2021, the lower compliance score of 60% for provider and member notification timeliness was due to missing provider fax notifications for four (4) standard prior authorizations.

➢ Based on a focused review of ten (10) Medi-Cal standard prior authorizations for February 2021, the lower compliance score of 80% for accuracy of member notice content was due to two (2) files missing member notifications.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

| Month(s) | File Classification | Resolution Timeliness | Provider and Member Notification Timeliness | Clinical Decision Making Review | Processing Accuracy | Written Response in Member's Preferred Language | Accuracy of Member Notice Content |
|---|---|---|---|---|---|---|---|
| December 2020 | 100% | 90% | 100% | 90% | 100% | 100% | 100% |
| January 2021 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| February 2021 | 100% | 90% | 90% | 100% | 100% | 100% | 100% |

➢ Based on a focused review of ten (10) Medi-Cal prior authorizations for February 2021, the lower compliance score of 90% for resolution timeliness was due to untimely resolution of one (1) standard prior authorization.


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

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- Based on a focused review of ten (10) Medi-Cal prior authorizations for February 2021, the lower compliance score of 90% for provider and member notification timeliness was due to untimely notification of one (1) standard prior authorization.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

| Month(s) | Classification Score | Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Appeals within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 0% | 100% |
| February 2021 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |

- No significant trends to report in February 2021.

- OneCare GARS: Standard Grievances

| Month(s) | Classification Score | Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Appeals within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 50% | 100% |
| February 2021 | 100% | 100% | 100% | 100% | 100% |

- No significant trends to report in February 2021.

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



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4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

| Month(s) | Classification Score | Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Appeals within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 0% | 100% |
| February 2021 | 100% | 70% | 100% | 30% | 100% |

> Based on a focused review of ten (10) OneCare Connect standard appeals for February 2021, the lower compliance score of 70% was due to three (3) files not being acknowledged within the timeframe.

> Based on a focused review of ten (10) OneCare Connect standard appeals for February 2021, the lower compliance score of 30% was due to seven (7) files exceeding the sixth (6th) grade reading level for member notice content.

- OneCare Connect GARS: Expedited Appeals

| Month(s) | Classification Score | Language Preference | Clinical Decision Making | Member Notice Content | Resolution of Appeals within 72 Hours of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| February 2021 | 100% | 100% | 100% | 100% | 0% |

> Based on a focused review of one (1) OneCare Connect expedited appeal for February 2021, the lower compliance score of 0% was due to one (1) file not being resolved within the required 72-hour timeframe.



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

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- OneCare Connect GARS: Standard Grievances

| Month(s) | Classification Score | Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt | Language Preference | Member Notice Content | Resolution of Grievance within ≤ 30 Calendar Days of Receipt |
|---|---|---|---|---|---|
| December 2020 | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report | Nothing to Report |
| January 2021 | 100% | 100% | 100% | 66.67% | 100% |
| February 2021 | 100% | 100% | 100% | 73.33% | 100% |

➢ Based on a focused review of fifteen (15) OneCare Connect standard grievances for February 2021, the lower compliance score of 73.33% was due to four (4) files having incomplete grievance resolutions.

- OneCare Connect Utilization Management: Standard Prior Authorizations

| Month(s) | File Classification | Resolution Timeliness | Provider and Member Notification Timeliness | Clinical Decision Making Review | Processing Accuracy | Written Response in Member's Preferred Language | Accuracy of Member Notice Content |
|---|---|---|---|---|---|---|---|
| December 2020 | 100% | 100% | 90% | 100% | 100% | 80% | 40% |
| January 2021 | 100% | 100% | 70% | 90% | 100% | 90% | 100% |
| February 2021 | 100% | 100% | 70% | 90% | 100% | 100% | 100% |

➢ Based on a focused review of ten (10) OneCare Connect prior authorizations for February 2021, the lower compliance score of 70% for provider and member notification timeliness was due to untimely notification of three (3) standard prior authorizations to providers.

➢ Based on a focused review of ten (10) One Care Connect standard prior authorizations for February 2021, the lower compliance score of 90% was due to one (1) file not following clinical hierarchy guidelines.

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



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- OneCare Connect Utilization Management: Expedited Prior Authorizations

| Month(s) | File Classification | Resolution Timeliness | Provider and Member Notification Timeliness | Clinical Decision Making Review | Processing Accuracy | Written Response in Member's Preferred Language | Accuracy of Member Notice Content |
|---|---|---|---|---|---|---|---|
| December 2020 | 100% | 50% | 70% | 80% | 100% | 100% | 10% |
| January 2021 | 100% | 100% | 80% | 70% | 100% | 100% | 90% |
| February 2021 | 100% | 100% | 100% | 100% | 100% | 90% | 60% |

  - ➢ Based on a focused review of ten (10) One Care Connect expedited prior authorizations for February 2021, the low compliance score of 90% was due to one (1) member notice not being sent in the member's preferred language.

  - ➢ Based on a focused review of ten (10) One Care Connect expedited prior authorizations for February 2021, the low compliance score of 60% was due to four (4) files exceeding the sixth ($6^{th}$) grade reading level for accuracy of member notice content.

5. Internal Audits: [a\]

- 2020 Medi-Cal Audit

  - ➢ During the fourth quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Medi-Cal medical grievances, appeals, prior authorizations, and quality of care processes to ensure compliance with universe, timeliness, clinical decision making, and processing requirements, as applicable, for the review period of July 1, 2020 – September 30, 2020.



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

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| Area Assessed | Acknowledgement Timeliness | Clinical Decision Making Review | Resolution Timeliness | Notification Timeliness | Written Response in Member Preferred Language | Accuracy of Member Notice Content | Processing Accuracy |
|---|---|---|---|---|---|---|---|
| **Medical Member Standard Grievances** | 100% | N/A | 100% | N/A | 100% | 87% | N/A |
| **Medical Member Expedited Grievances** | N/A | 100% | 100% | 100% | 100% | 100% | 100% |
| **Medical Member Standard Appeals** | 100% | N/A | 80% | N/A | 100% | 0% | 100% |
| **Medical Member Expedited Appeals** | N/A | N/A | 100% | N/A | 100% | 0% | 80% |
| **Medical Member Standard Appeals (Pharmacy)** | 100% | 100% | 100% | N/A | 100% | 100% | N/A |
| **Medical Member Expedited Appeals (Pharmacy)** | N/A | 100% | 50%* | N/A | 100% | 100% | N/A |
| **Medical Standard Prior Authorizations** | N/A | 100% | 60% | 80% | 100% | 100% | 100% |
| **Medical Expedited Prior Authorizations** | N/A | 100% | 40% | 80% | 100% | 80% | 100% |
| **Quality Improvement** | N/A | N/A | 0% | N/A | N/A | N/A | N/A |
| **Medical Standard Prior Authorizations (Pharmacy)** | N/A | 33% | 100% | 100% | 100% | 67% | 33% |
| **Medical Expedited Prior Authorizations (Pharmacy)** | N/A | 100% | 100% | 100% | 100% | 0% | 100% |

Medical Member Grievances (GARS)

- Accuracy of Member Notice Content
  - Two (2) of the fifteen (15) file samples reviewed were found to have resolution letters that did not address all member grievances.

Medical Member Appeals (GARS)

- Resolution Timeliness
  - Two (2) of the ten (10) file samples reviewed failed to meet timeliness requirements for standard appeals.
- Accuracy of Member Notice Content
  - All ten (10) file samples reviewed exceeded the sixth (6th) grade reading level requirements.
- Processing Accuracy
  - Two (2) of the ten (10) file samples reviewed failed to meet processing accuracy standards for expedited appeals.

Medical Member Appeals (Pharmacy)

- Resolution Timeliness
  - One (1) of the two (2) file samples reviewed failed to meet timeliness requirements for expedited appeals.

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



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Medical Prior Authorizations (Utilization Management)

- Resolution Timeliness
  - Five (5) of the ten (10) file samples reviewed failed to meet timeliness requirements for standard and expedited prior authorizations.
- Notification Timeliness
  - Two (2) of the ten (10) file samples reviewed failed to provide timely notification to providers.
- Accuracy of Member Notice Content
  - Two (2) of the ten (10) file samples reviewed failed to provide clinical terms in lay language.

Potential Quality of Care Issues (Quality Improvement)

- Resolution Timeliness
  - All six (6) file samples reviewed exceeded resolution timeframes.

Medical Prior Authorizations (Pharmacy)

- Clinical Decision Making Review
  - Two (2) of the five (5) file samples reviewed displayed incorrect final dispositions.
- Accuracy of Member Notice Content
  - One (1) of the five (5) file samples reviewed exceeded the sixth ($6^{th}$) grade reading level.
  - In one (1) of the five (5) file samples reviewed, the Notice of Action (NOA) failed to include an explanation as to why the request was denied.
  - In one (1) of the five (5) file samples reviewed, there was no reference to the criteria and guidelines used to review the member's NOA.
- Processing Accuracy
  - Two (2) of the five (5) file samples reviewed displayed incorrect final dispositions.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Medi-Cal medical grievances, appeals, prior authorizations, and quality of care processes. The A&O department continues to work with the impacted departments to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.



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

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

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

| Month | Timely Urgent Requests | Clinical Decision Making (CDM) for Urgent Requests | Letter Score for Urgent Requests | Timely Routine Requests | Timely Denials | CDM for Denials | Letter Score for Denials | Timely Modified Requests | CDM for Modified Requests | Letter Score for Modified Requests | Timely Deferrals | CDM for Deferrals | Letter Score for Deferrals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2020 | 85% | 94% | 97% | 93% | 84% | 92% | 93% | 89% | 95% | 99% | 60% | 100% | 97% |
| December 2020 | 86% | 96% | 97% | 86% | 91% | 95% | 96% | 82% | 94% | 99% | 97% | 89% | 97% |
| January 2021 | 89% | 95% | 98% | 94% | 93% | 93% | 99% | 92% | 95% | 100% | 95% | 89% | 97% |

- Based on a focused review of select files, only one (1) health network drove the lower compliance score for timeliness during the month January 2021. Of the seven (7) files submitted by the health network, one (1) file was marked deficient for timeliness.

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for clinical decision making (CDM) during the month of January 2021. Of the thirty-four (34) files submitted in the aggregate by the four (4) health networks, twelve (12) files were deficient for CDM. The lower scores for CDM were due to the following:
  - Failure to include appropriate professional who makes decision
  - Failure to cite criteria for decision

- Based on the overall universe of Medi-Cal authorizations for December 2020, CalOptima's health networks received an aggregate compliance score of 99.87% for timely processing of routine authorization requests and a compliance score of 98.90% for timely processing of expedited authorization requests.

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



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

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- Medi-Cal Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| November 2020 | 88% | 85% | 90% | 85% |
| December 2020 | 95% | 97% | 97% | 92% |
| January 2021 | 94% | 98% | 98% | 96% |

- ➢ Based on the overall universe of Medi-Cal claims for December 2020, CalOptima's health networks received an overall compliance score of 95% for timely processing of claims.

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

7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

| Month | Timeliness for Expedited Initial Organization Determinations (EIOD) | Clinical Decision Making for EIOD | Letter Score for EIOD | Timeliness for Standard Organization Determinations (SOD) | Letter Score for SOD | Timeliness for Denials | Clinical Decision Making for Denials | Letter Score for Denials |
|---|---|---|---|---|---|---|---|---|
| November 2020 | 94% | Nothing to Report | 80% | 100% | 92% | 84% | 93% | 100% |
| December 2020 | 100% | 100% | 91% | 100% | 91% | 100% | 92% | 93% |
| January 2021 | 98% | 100% | 93% | 100% | 89% | 100% | 88% | 100% |

- ➢ Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness during the month of January 2021. Of the ten (10) files submitted by the health network, one (1) file was deficient for timeliness.



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

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- ➢ Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of January 2021. Of the eleven (11) files submitted by the two (2) health networks, two (2) files were deficient for CDM. The lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information

- ➢ Based on a focused review of select files, three (3) health networks drove the lower compliance letter score during the month of January 2021. Of the thirty (30) files submitted by the three (3) health networks, eighteen (18) files were deficient due to the health networks' failure to provide letters with a description of services in lay language.

- ➢ Based on the overall universe of OneCare authorization requests for CalOptima's health networks for December 2020, CalOptima's health networks received an overall compliance score of 99% for timely processing of standard Part C authorization requests and 86% for timely processing of expedited Part C authorization requests.

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

- OneCare Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| November 2020 | 88% | 86% | 88% | 88% |
| December 2020 | 96% | 96% | 99% | 100% |
| January 2021 | 96% | 96% | 100% | 94% |

- ➢ Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 100% in December 2020 to 94% in January 2021 due to missing documents that are required for processing accurate payment on claims.

- ➢ Based on the overall universe of OneCare claims for CalOptima's health networks for December 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:

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



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- 94.29% for non-contracted clean claims paid or denied within 30 calendar days of receipt
- 99.65% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

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

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

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

| Month | Timeliness for Urgent Requests | Clinical Decision Making (CDM) for Urgent Requests | Letter Score for Urgent Requests | Timeliness for Routine Requests | Letter Score for Routine Requests | Timeliness for Denials | CDM for Denials | Letter Score for Denials | Timeliness for Modified Requests | CDM for Modified Requests | Letter Score for Modified Requests |
|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2020 | 83% | 98% | 95% | 98% | 92% | 84% | 85% | 95% | 77% | 92% | 100% |
| December 2020 | 95% | 87% | 96% | 88% | 94% | 81% | 83% | 90% | 85% | 95% | 97% |
| January 2021 | 99% | 92% | 95% | 93% | 95% | 93% | 94% | 93% | 98% | 100% | 100% |

➢ Based on a focused review of select files, two (2) health networks drove the lower compliance letter score during the month of January 2021. Of the twenty (20) files submitted by the two (2) health networks, eleven (11) files were deficient due to the health networks' failure to provide letters with a description of services in lay language.

➢ Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for December 2020, CalOptima's health networks received an overall compliance score of 99.91% for timely processing of routine authorization requests and 99.15% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as, but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions ---

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



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to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

| Month | Paid Claims Timeliness | Paid Claims Accuracy | Denied Claims Timeliness | Denied Claims Accuracy |
|---|---|---|---|---|
| November 2020 | 87% | 85% | 90% | 91% |
| December 2020 | 93% | 94% | 99% | 97% |
| January 2021 | 85% | 94% | 100% | 96% |

➢ Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 93% in December 2020 to 85% in January 2021 due to untimely processing of claims. The lower score was driven by three (3) health networks with fifteen (15) out of thirty (30) files marked deficient for timeliness.

➢ Based on the overall universe of OneCare Connect claims for CalOptima's health networks for December 2020, CalOptima's health networks received the following overall compliance scores:
  – 94.24% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  – 97.88% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
  – 99.77% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

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

9. First-Tier Entities (FTE):

- During the first quarter of 2021, CalOptima's Audit & Oversight department conducted annual audits of four (4) first-tier entities (FTEs) to ensure compliance with applicable laws, regulations, contractual requirements, and CalOptima policies. The FTEs audited included vendors for personal emergency response services, nurse triage services, health and wellness services, and accompaniment services. The audit areas assessed included the contractual, compliance, information systems, and sub-contractual obligations of the FTE.

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

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- The scores below reflect the average across all four (4) FTEs audited.

    ➢ The lower score related to the sub-contractual portion of the audit was due to one (1) FTE that failed to provide evidence of their oversight of their sub-contractual relationships (e.g., policies related to monitoring and audits, delegation agreements). CalOptima's Audit & Oversight department has issued a request for a corrective action plan (CAP) to this FTE to remediate the deficiency.

| Audit Area | Contractual Obligations | Compliance | Information Systems | Sub-Contractual |
|---|---|---|---|---|
| Overall Average Score | 100% | 95.61% | 92.04% | 66.66% |


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

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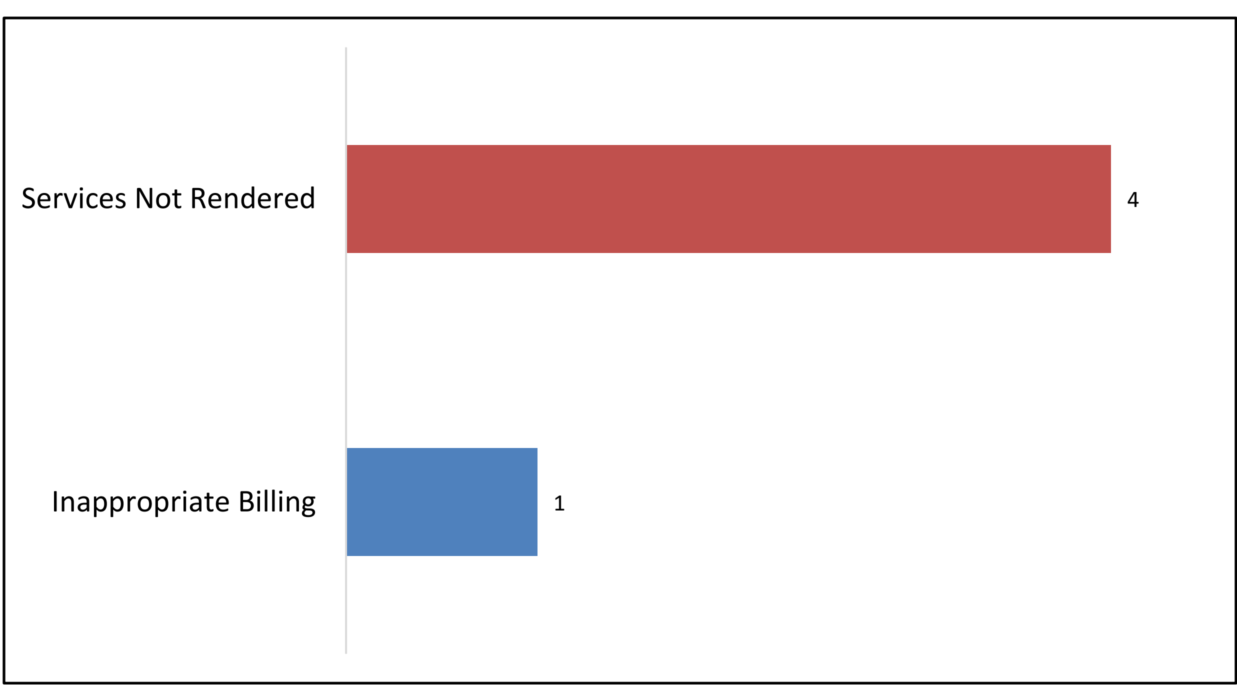
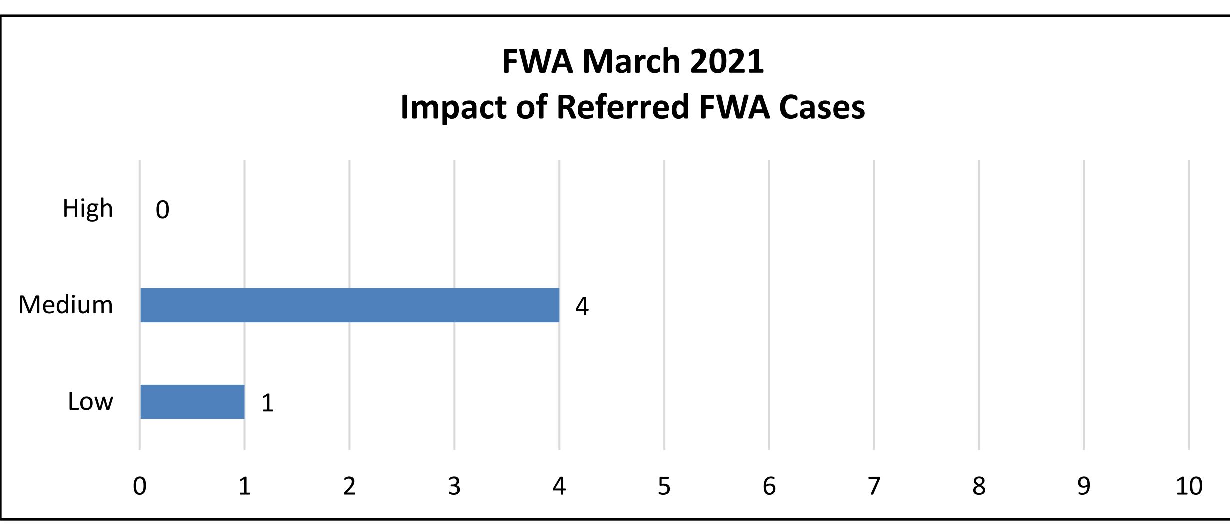
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in March 2021)




| | |
|---|---|
| Total Number of New Cases Referred to DHCS (State) | 5 |
| Total Number of Closed Cases Referred to I-MEDIC (CMS) | 0 |
| **Total Number of Referrals Reported** | **5** |


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

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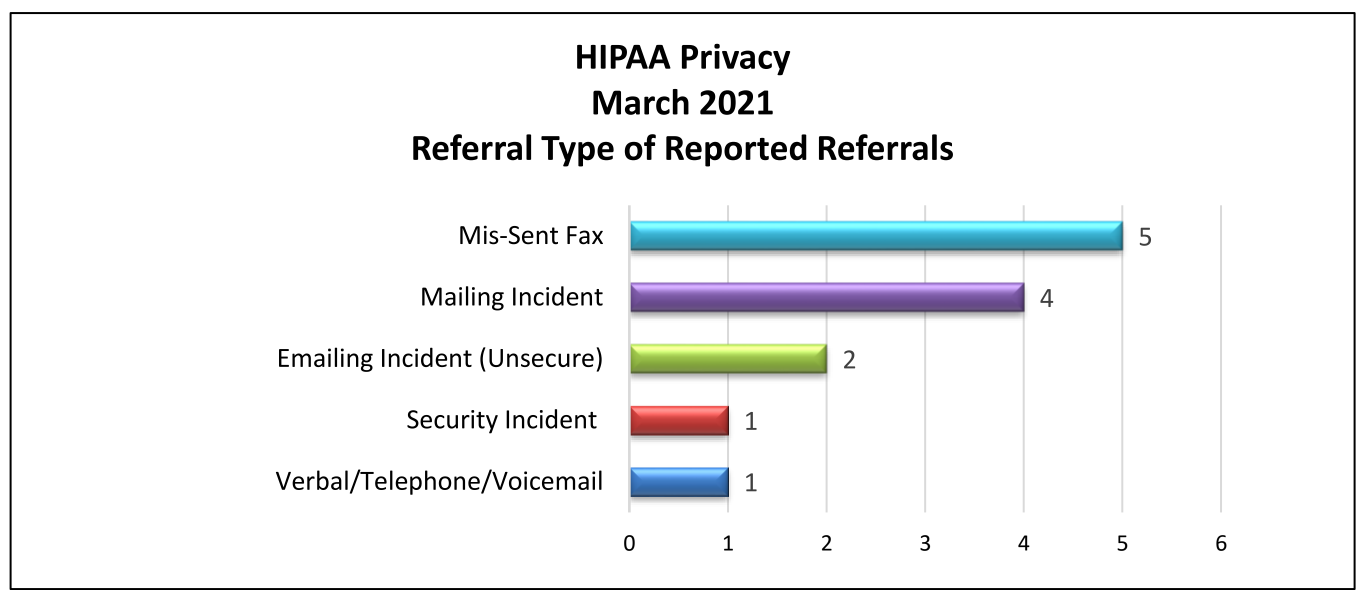
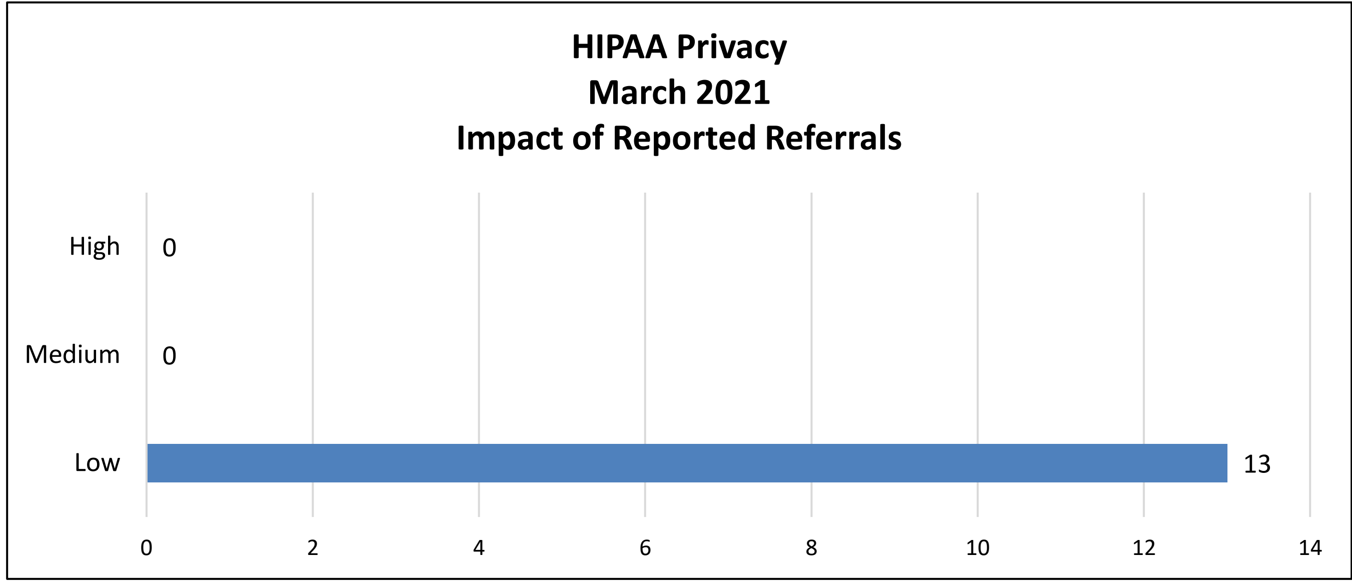
E. Privacy Update: (March 2021)




| | |
|---|---|
| Total Number of Referrals Reported to DHCS (State) | 13 |
| Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR) | 0 |
| **Total Number of Referrals Reported** | **13** |

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



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M E M O R A N D U M

April 15, 2021

**To:** CalOptima

**From:** Akin Gump Strauss Hauer & Feld, LLP

**Re:** April Board of Directors Report

Congressional Democrats and the Administration are making plans to move the next massive legislative package, a comprehensive infrastructure plan that could also be passed using budget reconciliation. The release of the President's "skinny budget" has also given appropriators some information they need to commence with hearings on fiscal 2022 spending, with a more detailed Budget Request set to be released later this spring. This report covers developments through April 15, 2021.

**FY 2022 Budget/Appropriations**

On April 9, the White House released a much-anticipated outline of the President's Fiscal Year (FY) 2022 Budget Request. The "skinny budget" document provides an overview of $1.5 trillion in funding for the next fiscal year, including $131.7 billion for the Department of Health and Human Services (HHS)—a 23.5 percent increase from the 2021 enacted level. In particular, the HHS Budget Request includes:

- An increase of $1.6 billion in funding for the Centers for Disease Control and Prevention (CDC);
- An investment of $905 million for the Strategic National Stockpile (SNS);
- A $9 billion increase for the National Institutes of Health (NIH), including $6.5 billion to establish the Advanced Research Projects Agency for Health (ARPA-H);
- $670 million in funding to combat HIV/AIDS;
- $1.6 billion for the Community Mental Health Services Block Grant program;
- An increase of $150 million for CDC's Social Determinants of Health program;
- More than $200 million to reduce maternal mortality and end race-based disparities in maternal health;
- $551 million for home and community-based services (HCBS);
- The establishment of a new Office of Climate Change and Health Equity; and
- Increased funding for rural health care.

The budget outline also highlights a $10.7 billion investment across several agencies for programs and initiatives to combat the opioid crisis. The White House is expected to release a

more detailed Budget Request later this spring that will include additional information on discretionary funding and mandatory spending proposals.

House and Senate Committees are moving forward with the appropriations process. House Members have until late April to submit programmatic, language-based, and Community Project Funding requests to the appropriate subcommittees.

**Infrastructure Package**

On March 31, President Biden unveiled plans for a sweeping infrastructure and climate change bill, the American Jobs Plan Act, which addresses areas including transportation, energy, racial equity, education, and supply chains. Speaker Pelosi has set a July 4 goal for the House to pass the package, while Senate Democrats have signaled that they may advance the measure through budget reconciliation. Senate Minority Leader McConnell has said he expects to oppose the roughly $2 trillion package. Among other proposals, the plan calls for $400 billion in funding for home- and community-based care services as well as an extension of the Medicaid Money Follows the Person program. The plan also includes funding for broadband expansion and public health preparedness. The President may also release a separate plan later in April addressing health care and child care.

On April 5, Senate Majority Leader Chuck Schumer (D-NY) announced that the Senate parliamentarian informed him that Democrats can use the budget reconciliation process again this year by revising the FY 2021 budget resolution. Lawmakers could also include reconciliation instructions in the FY 2022 bill, which raises the possibility of splitting the President's proposed infrastructure plan into multiple vehicles that could pass the Senate by simple majority.

**Committee Activity**

House and Senate committees continue to hold hearings on a number of health care issues. On March 23, the House Energy and Commerce Committee's Health Subcommittee held a hearing to consider a number of bills to expand coverage and affordability, including several measures related to Medicaid:

- H.R. 340, the Incentivizing Medicaid Expansion Act of 2021, would establish incentives to expand Medicaid by providing states with 100 percent FMAP for expansion beneficiaries for the first three years and gradually decreasing the rate to 93 percent by year six.
- H.R. 1738, the Stabilize Medicaid and CHIP Coverage Act, would permit Medicaid and CHIP beneficiaries to maintain eligibility for 12 consecutive months once enrolled.

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- H.R. 1784, the Medicaid Report on Expansion of Access to Coverage for Health Care (REACH) Act, would require nonexpansion states to submit annual reports to HHS with data on their Medicaid programs and uninsured rates, including the number of uninsured individuals in the state at or below 138 percent of FPL, and information on current state eligibility levels for different eligibility groups.

The Health Subcommittee also held a hearing on April 14 to examine the opioid and drug abuse crisis, which according to many indicators has worsened during the COVID-19 pandemic. Regina LaBelle, Acting Director of the Office of National Drug Control Policy (ONDCP), and a panel of addiction experts and advocates testified before the Subcommittee. Members also considered a slate of measures related to substance use disorders (SUDs), including H.R. 955, the Medicaid Reentry Act, which would extend Medicaid eligibility to incarcerated individuals 30 days before their release.

On March 17, the Senate Finance Committee held a hearing on nursing homes and how they were affected by COVID-19. Discussions focused on infection control measures, best practices in the future, and the need to address chronic underfunding and understaffing in nursing homes. The Finance Committee will hold a hearing on April 15 to consider the nominations of Chiquita Brooks-LaSure to serve as Centers for Medicare and Medicaid Services (CMS) Administrator and Andrea Palm to serve as HHS Deputy Secretary.

On March 25, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing to examine health equity and disparities in the wake of the pandemic. Members on both sides of the aisle discussed ways to improve the diversity of clinical trials and expand access to vaccines.

**Vaccine Update**

States and major pharmacy chains suspended administration of Johnson & Johnson's COVID-19 vaccine after the Food and Drug Administration (FDA) and CDC recommended a temporary halt and reported that six women who received the vaccine had experienced a rare blood clotting event. CDC's Advisory Committee on Immunization Practices (ACIP) met on April 14 to discuss the cases but delayed taking a vote on the pause or issuing any interim recommendations until more data is available. Some advisory committee members raised concerns that a prolonged pause would exacerbate health disparities; the Johnson & Johnson vaccine has been touted as a good option for rural and underserved areas that lack the cold-chain infrastructure needed to store the Pfizer and Moderna mRNA products. The U.S. is averaging about 3.3 million COVID-19 vaccinations per day, leading the world in total vaccinations. Still, new cases continue to tick up and there are concerns about the spread of more contagious variants.

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Edelstein Gilbert Robson & Smith LLC

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

April 16, 2021

**LEGISLATIVE UPDATE**
**Edelstein Gilbert Robson & Smith LLC**

As you've read or heard, Governor Newsom announced plans last week to reopen the state by June 15. With vaccination rates picking up in recent weeks, California hit a milestone of vaccinating 20 million Californians. 4 million of those vaccinations have occurred in the state's disadvantaged communities that have been hit hardest by the pandemic. That is critical for the Governor who has promised to make equity central to vaccine distribution. At the same time, infection rates and hospitalizations have remained relatively low and steady.

The Governor's announcement came with very few caveats. There would be some limitations on large gatherings. California's mask mandate will remain in effect with the Governor citing it as the number one means of mitigating the spread of COVID-19. Beyond that, the Governor explained that if there are enough vaccines for those 16 and older and hospitalization rates remain low and stable, state guidance will allow reopening on June 15.

In addition to being a legitimate move given the state of the pandemic, reopening California's economy is politically wise. Frustration with the state's complex web of county tiers and on-again-off-again shutdowns has bolstered the efforts of recall proponents. With a recall election likely in the fall, if the state is on track to reopen in June the Governor will be able to market his success to voters in the leadup to the election.

However, there are a few unknowns that could frustrate the Governor's reopening efforts.

**Specific Metrics**

In making his announcement, the Governor was asked what specific standards he would use to assess vaccine availability and hospitalization to determine if the state could indeed reopen by June 15. Understandably, the Governor does not have that information yet. He and his Secretary of Health and Human Services explained that they would assess the variants in play at the time and whether those who had been vaccinated were being hospitalized. The Governor also noted that he would need to work with the Counties to put precise metrics to those standards.

There are a number of threats that are outside the Governor's control including the possibility of California experiencing the spring surge seen elsewhere, a mutant variant spreading the virus despite vaccination, or a serious interruption in vaccine supply, such as the pause in distributing the Johnson & Johnson vaccine. Without knowing exactly what metrics the Governor will use for safe reopening, it's very hard to assess how likely an uptick in infection or hospitalization would be to impact his plans.



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**Localism is Determinative**
Early in the pandemic, Governor Newsom coined the rather wordy phrase “localism is determinative.” Essentially, what he means is that the state will allow local health officials to go beyond state guidance and do what they felt was needed to keep their communities safe. At times, counties, particularly those in the Bay Area, have opted to keep businesses closed despite being cleared to reopen. In fact, a collection of Bay Area counties issued their own shelter in place orders prior to the Governor’s historic announcement last March.

Local decisions could foil the Governor’s plans for reopening. He has made it clear that Counties will have the option to remain closed longer. Perhaps more importantly, school districts will maintain control over whether they reopen and will have to bargain with their employees to do so. While the Governor has been clear that there will be no barriers to schools reopening after June 15, he will not be compelling schools to do so. If they do not reopen, some parents could find themselves in the difficult position of not being able to return to work because they have no other option for childcare.

**What About the Legislature?**
While most Californians have bigger things to worry about, those of us in Sacramento can’t help but wonder what this means for the reopening of the Capitol. As more vaccines have been administered, legislators have begun to allow more of their personal staff to return to in person work. However, lobbyists and the general public continue to be limited to attending hearings for purposes of testifying.

Whether talking to legislators, staff, or other lobbyists, most are eager to return to in person work once vaccinated. However, legislative leadership has been eerily silent on the matter since the Governor’s announcement last week.

We will keep you apprised of further developments.

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# 2021–22 Legislative Tracking Matrix

## COVID-19 (CORONAVIRUS)

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 454**<br>**Rodriguez** | **Provider Supplemental Payments:** Would allow the Department of Managed Health Care (DMHC) to require health plans to provide supplemental payments and/or nonmonetary support to any severely impacted providers during and for 60 days after a public health emergency or disaster declaration. DMHC may require health plans to provide rate increases, one-time payments, personal protective equipment, and/or other equipment and business expenses to ensure the continued operation of the practice, but no more than the total payment amount that the plan would have paid in an average year. Plans must include any payments in their medical loss ratio calculation as a direct patient care expense. | **04/08/2021**<br>Amended; re-referred to Assembly Health Committee<br><br>**02/08/2021**<br>Introduced | CalOptima: Watch<br>CAHP: Oppose<br>LHPC: Oppose |
| **SB 242**<br>**Newman** | **Provider Reimbursement for Medically Necessary Equipment:** Would allow physicians and dental providers to be reimbursed for medically necessary business expenses, in compliance with a public health order, to treat and reduce the spread of COVID-19 or other infectious diseases in the workplace during a public health emergency. Reimbursable expenses would include personal protective equipment, infection control supplies, testing supplies and processing, and related information technology expenses. The reimbursement rates for Medi-Cal providers would be determined and paid by the Department of Health Care Services (DHCS). | **03/15/2021**<br>Amended; re-referred to Senate Appropriations Committee<br><br>**03/10/2021**<br>Passed Senate Health Committee<br><br>**01/21/2021**<br>Introduced | CalOptima: Watch<br>CAHP: Oppose<br>LHPC: Oppose |

## BEHAVIORAL HEALTH

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 77**<br>**Petrie-Norris** | **Jarrod's Law:** Effective January 1, 2026, would require any substance use disorder treatment programs not currently licensed by a state agency to become licensed by DHCS. After review and approval of applications and completion of an on-site review, DHCS would issue a license for a period of two years, subject to renewal. Licensed programs would be subject to quality standards regarding patient eligibility and assessments, record-keeping, staff qualifications, medically necessary treatment and recovery services, and administration of medication. | **03/25/2021**<br>Amended; re-referred to Assembly Health Committee<br><br>**12/07/2020**<br>Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 563 Berman** | **Office of School-Based Health Programs:** Would establish the Office of School-Based Health Programs within the State Department of Education, no later than July 1, 2022. The office would administer current health programs within the department, including the local educational agencies (LEA) Medi-Cal Billing Option Program and Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) services, as well as coordinate with DHCS and LEAs to increase access to and expand the scope of school-based Medi-Cal programs. | **04/06/2021** Amended; re-referred to Assembly Health Committee<br><br>**03/24/2021** Passed Assembly Education Committee<br><br>**02/11/2021** Introduced | CalOptima: Watch |
| **AB 586 O'Donnell** | **School Health Demonstration Project:** Would establish the School Health Demonstration Project to expand comprehensive health and mental health access to students. Under the two-year pilot program, the State Department of Education would provide support, technical assistance and $500,000 grants per year to several LEAs in order to participate in additional Medi-Cal funding opportunities and build partnerships with Medi-Cal managed care plans, county mental health plans and private health plans. | **04/07/2021** Passed Assembly Education Committee; referred to Assembly Health Committee<br><br>**02/11/2021** Introduced | CalOptima: Watch |
| **AB 822 Rodriguez** | **Emergency Psychiatric Observations:** Would add outpatient psychiatric observation services as a covered Medi-Cal nonspecialty mental health benefit, when necessary, for emergency psychiatric treatment. Medi-Cal managed care plans (MCPs) would be required to reimburse the observing provider. | **03/04/2021** Amended; re-referred to Assembly Health Committee<br><br>**02/16/2021** Introduced | CalOptima: Watch<br>LHPC: Oppose Unless Amended |
| **AB 942 Wood** | **Medically Necessary Services:** Similar to SB 279, would allow Medi-Cal to provide reimbursement for clinically appropriate and covered behavioral health benefits before a diagnosis. | **02/25/2021** Referred to Assembly Health Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch |
| **AB 988 Bauer-Kahan, Berman, Chiu, Quirk-Silva, Ting** | **988 Crisis Hotline:** No later than July 16, 2022, would implement the state's 988 Crisis Hotline using the digits 9-8-8 established by federal law as the National Suicide Prevention Lifeline. The 988 Crisis Hotline would connect individuals experiencing a mental health crisis with suicide prevention and mental health crisis counselors. | **03/04/2021** Referred to Assembly Health Committee and Assembly Communications and Conveyance Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **SB 106 Umberg** | **Mental Health Services Act (MHSA) Focus Populations:** Would remove the requirement that County mental health programs obtain approval from the MHSA Commission to spend MHSA funds for their "innovative programs" that provide a full spectrum of community services for beneficiaries to achieve their identified goals. | **03/23/2021** Amended; re-referred to Senate Health Committee<br><br>**01/05/2021** Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **SB 221 Wiener** | **Timely Access to Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment—in alignment with the current time frame for the initial appointment. Although this bill would modify the Knox-Keene Act, which does not apply to CalOptima, DHCS would be expected to align standards in the Medi-Cal managed care contracts in accordance with current practice. | **03/22/2021** Amended; re-referred to Senate Appropriations Committee<br><br>**03/17/2021** Passed Senate Health Committee<br><br>**01/13/2021** Introduced | CalOptima: Watch<br>CAHP: Oppose |
| **SB 279 Pan** | **Medically Necessary Services:** Similar to AB 942, would allow Medi-Cal to provide reimbursement for clinically appropriate and covered behavioral health benefits before a diagnosis. | **03/03/2021** Re-referred to Senate Health Committee<br><br>**01/29/2021** Introduced | CalOptima: Watch |
| **SB 508 Stern** | **Mental Health Coverage at Schools:** Would authorize an LEA to have an appropriate mental health professional provide brief interventions at a school campus, when necessary, for all referred students, including students with a health care service plan, health insurance or coverage through a Medi-Cal MCP, but not those covered by a county mental health plan. This bill would also allow the behavioral health services provided by the LEA to be conducted via telehealth. | **02/25/2021** Referred to Senate Health Committee and Senate Education Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch |
| **SB 562 Portantino** | **Autism Spectrum Disorder (ASD) Treatment:** Would revise and expand the definitions of those providing care and support to individuals with ASD and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental, Individual-differences and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, would be authorized to be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services will not been denied or limited if a parent or caregiver is unable to participate. | **04/06/2021** Passed Senate Human Services Committee; referred to Senate Health Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **SB 773 Roth** | **Medi-Cal Incentive Payments for School-Based Behavioral Health:** Would require DHCS to make incentive payments to Medi-Cal MCPs for the 2022–24 rating period if plans increase access to preventative and behavioral health services for K–12 students through targeted interventions by school-based behavioral health providers. DHCS will develop the interventions and associated metrics with MCPs, county mental health plans and schools; DHCS will develop payment amounts. | **03/18/2021** Re-referred to Senate Health Committee<br><br>**02/19/2021** Introduced | CalOptima: Watch |

## CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 875**<br>**Wood** | **CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS):** Similar to SB 256, would require ECM to be added as a covered benefit for Medi-Cal beneficiaries. This would include the coordination of all primary, acute, behavioral, oral, and long-term services and supports (LTSS). Additionally, would require a Medi-Cal MCP to list available ILOS on its website and in the beneficiary handbook as well as share data with DHCS related to beneficiary utilization of ILOS. ILOS offered by the health plan must be incorporated into DHCS' calculation of the MCP's capitation rate. | **02/25/2021**<br>Referred to Assembly Health Committee<br><br>**02/17/2021**<br>Introduced | CalOptima: Watch |
| **AB 1160**<br>**Rubio** | **Medically Tailored Meals:** Would allow Medi-Cal MCPs to offer medically tailored meals to beneficiaries as an ILOS, effective January 1, 2022. | **03/04/2021**<br>Referred to Assembly Health Committee<br><br>**02/18/2021**<br>Introduced | CalOptima: Watch |
| **SB 256**<br>**Pan** | **CalAIM ECM and ILOS:** Similar to AB 875, would require ECM to be added as a covered benefit for Medi-Cal beneficiaries. This would include the coordination of all primary, acute, behavioral, oral, and LTSS. Additionally, would require a Medi-Cal MCP to list available ILOS on its website and in the beneficiary handbook as well as share data with DHCS related to beneficiary utilization of ILOS. ILOS offered by the health plan must be incorporated into DHCS' calculation of the MCP's capitation rate. | **02/03/2021**<br>Referred to Senate Health Committee<br><br>**01/26/2021**<br>Introduced | CalOptima: Watch |
| **RN 21 08858**<br>**Trailer Bill** | **CalAIM:** Would codify various provisions of the CalAIM Proposal as revised by DHCS on January 8, 2021, for which implementation requires changes in state law. | **02/01/2021**<br>Published on the Department of Finance website | CalOptima: Watch |

## COVERED BENEFITS

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **H.R. 56**<br>**Biggs** | **Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include a food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. | **01/04/2021**<br>Introduced; referred to House Committees on Energy and Commerce, Ways and Means and Armed Services | CalOptima: Watch |
| **AB 114**<br>**Maienschein** | **Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit for any beneficiary who is at least 1 year of age and is receiving inpatient services in an intensive care unit. The benefit would include individual sequencing, trio sequencing for one or more parent and their baby, and ultra-rapid sequencing. | **04/05/2021**<br>Amended; re-referred to Assembly Health Committee<br><br>**12/17/2020**<br>Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 342 Gipson** | **Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for a colorectal cancer screening and laboratory test recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, would prohibit health plans from imposing cost sharing on colonoscopies for those between 50 and 75 years of age. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider. | **03/26/2021** Amended; re-referred to Assembly Appropriations Committee<br><br>**03/23/2021** Passed Assembly Health Committee<br><br>**01/28/2021** Introduced | CalOptima: Watch |
| **AB 797 Wicks** | **Infertility Treatment:** Effective January 1, 2022, would require all health plans to provide coverage for infertility treatments, including in vitro fertilization, to any beneficiary who is unable to reproduce. Would also remove coverage exemptions for religiously affiliated health plans and employer sponsors. | **02/25/2021** Referred to Assembly Health Committee<br><br>**02/16/2021** Introduced | CalOptima: Watch |
| **SB 245 Gonzalez** | **Abortion Services:** Would prohibit a health plan from imposing a deductible, coinsurance, copayment or Medi-Cal cost-sharing on all abortion services, including any follow-up care, provided as of January 1, 2022. Likewise, a health plan may not require a prior authorization or impose an annual or lifetime limit on such coverage. | **04/07/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee<br><br>**01/22/2021** Introduced | CalOptima: Watch<br>CAHP: Oppose |
| **SB 306 Pan** | **Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home STD test kits and any associated laboratory fees. Subject to funding by the State Legislature, would also authorize Medi-Cal reimbursement for STD-related services at the same rate as comprehensive family planning services, even when the patient is not at risk of becoming pregnant or in need of contraception | **04/07/2021** Passed Senate Health Committee; referred to Senate Business, Professions and Economic Development Committee<br><br>**02/04/2021** Introduced | CalOptima: Watch<br>CAHP: Oppose |
| **RN 21 05566 Trailer Bill** | **Delayed Suspension of Medi-Cal Adult Optional Benefits:** Would delay the suspension of certain Medi-Cal adult optional benefits, which are currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Extended optional benefits include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes. | **02/02/2021** Published on the Department of Finance website | CalOptima: Watch |
| **RN 21 05595 Trailer Bill** | **Delayed Suspension of Medi-Cal Postpartum Care Extension:** Would delay the suspension of Medi-Cal postpartum expanded eligibility, which is currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Postpartum expanded eligibility allows Medi-Cal beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. Upon the discontinuation of postpartum expanded eligibility on December 31, 2022, postpartum care would terminate 60 days after the last day of pregnancy. | **02/02/2021** Published on the Department of Finance website | CalOptima: Watch |

# MEDI-CAL ELIGIBILITY

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 4 Arambula** | **Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office previously projected this expansion would cost approximately $900 million General Fund (GF) in 2019–20 and $3.2 billion GF each year thereafter, including the costs of In-Home Supportive Services. | **01/11/2021** Referred to Assembly Health Committee<br><br>**12/07/2020** Introduced | CalOptima: Watch<br>CAHP: Support<br>LHPC: Support |
| **AB 112 Holden** | **Inmate Eligibility Extension:** Would delay the termination date of Medi-Cal eligibility for non-juvenile inmates from one year of elapsed incarceration to three years of elapsed incarceration. For juvenile inmates, Medi-Cal eligibility would not be terminated until three years after their status as a juvenile has ended. While Medi-Cal benefits and payments would still be suspended throughout incarceration, as required by federal law, this bill would allow inmates to remain Medi-Cal eligible for a longer period before termination. The lengthened eligibility period would allow more inmates to immediately reinstate their benefits upon release, rather than initiate the standard redetermination process. | **03/26/2021** Amended; re-referred to Assembly Appropriations Committee<br><br>**03/23/2021** Passed Assembly Health Committee<br><br>**12/17/2020** Introduced | CalOptima: Watch |
| **AB 470 Carrillo** | **Elimination of Asset Consideration:** Would prohibit the consideration of any assets or property in determining Medi-Cal eligibility under any aid category, subject to federal approval. This would increase the number of individuals eligible for Medi-Cal in certain aid categories. | **04/06/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/08/2021** Introduced | CalOptima: Watch<br>LHPC: Support |
| **SB 56 Durazo** | **Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million GF, $21 million federal funds) for approximately 25,000 undocumented seniors. In-Home Supportive Services are estimated to cost $13 million GF. | **03/22/2021** Passed Senate Appropriations Committee<br><br>**03/10/2021** Passed Senate Health Committee<br><br>**12/07/2020** Introduced | CalOptima: Watch<br>CAHP: Support<br>LHPC: Support |

# MEDI-CAL OPERATIONS AND ADMINISTRATION

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **H.R. 1738 Dingell** | **Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. | **03/10/2021** Introduced; referred to House Energy and Commerce Committee | CalOptima: Watch<br>ACAP: Support |
| **S. 646 Brown** | **Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. | **03/09/2021** Introduced; referred to Senate Finance Committee | CalOptima: Watch<br>ACAP: Support |

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| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 685 Maienschein** | **Emergency Services Claims Review:** Would require a health plan, before denying any claim or reducing any payment regarding emergency services, to obtain an independent review of the patient's medical record by an emergency medicine physician. If the reviewer determines that the claim should be denied or payment should be reduced, the reviewer must indicate the reason in writing and provide supporting evidence. | **03/11/2021** Amended; re-referred to Assembly Health Committee<br><br>**02/16/2021** Introduced | CalOptima: Watch |
| **AB 862 Chen** | **Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning July 1, 2022. Would require DHCS to calculate the annual QAF for a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period. | **02/25/2021** Referred to Assembly Health Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch |
| **AB 1050 Gray** | **Medi-Cal Beneficiary Communications Consent:** Would amend the application for Medi-Cal benefits to include a written consent to receive all forms of communications from DHCS, county welfare departments, MCPs, and providers regarding the beneficiary's care or benefits. | **03/04/2021** Referred to Assembly Health Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **AB 1082 Waldron** | **California Health Benefits Review Program (CHBRP) Extension:** Would extend current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed states legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill would also increase the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022. | **03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch<br>CAHP: Support In Concept |
| **AB 1107 Boerner Horvath** | **In-Network Ground Emergency Medical Transportation (GEMT):** Effective January 1, 2022, would require health plans covering GEMT to include those services as an in-network benefit. | **03/04/2021** Referred to Assembly Health Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **AB 1131 Wood** | **Health Information Exchange:** Would establish a statewide health information network (HIN) to facilitate the required exchange of patient data among all health plans, health systems, providers, hospitals, skilled nursing facilities and laboratories in California. Exchanged data would include clinical summaries, claims, encounter data, laboratory data, eligibility files, and race and ethnicity information. Would require the California Health and Human Services Agency (CHHS) to contract with a vendor to operate the HIN, subject to renewal every four years. | **04/06/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **AB 1162 Villapadua** | **Claims Processing Timeline; Prior Authorizations During Emergency:** Would shorten the timeline for health plans to process submitted claims from 30 days (or 45 days for health maintenance organizations) to 20 days for all health plans.<br><br>Additionally, would allow DMHC to suspend health plan requirements for prior authorizations in any county where a declared state of emergency has impacted beneficiaries or providers. | **03/04/2021** Referred to Assembly Health Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 1355**<br>**Levine** | **Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system for Medi-Cal MCPs, effective January 1, 2022. The bill would also provide every Medi-Cal beneficiary filing a grievance with access to an IMR. | **03/04/2021**<br>Referred to Assembly Health Committee<br><br>**02/19/2021**<br>Introduced | CalOptima: Watch |
| **AB 1400**<br>**Kalra, Lee, Santiago** | **California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, ancillary health care or social services covered by regional centers for people with developmental disabilities, the Knox-Keene Act and Medicare. | **02/19/2021**<br>Introduced | CalOptima: Watch |
| **SB 250**<br>**Pan** | **Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2023, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for two years. A provider would qualify if their number of denied prior authorizations requests (which were not appealed or were lost upon appeal) are both within a certain range of the average numbers for the same specialty in the same region. Every two years, the plan would audit 10% of the provider's records to redetermine qualification for "deemed approved" status. | **03/17/2021**<br>Passed Senate Health Committee; referred to Senate Appropriations Committee<br><br>**01/25/2021**<br>Introduced | CalOptima: Watch<br>CAHP: Oppose |
| **SB 371**<br>**Caballero** | **Health Information Technology and Exchange:** Would require DHCS to apply for federal funding from the American Rescue Plan Act of 2021 or the Medicaid Information Technology Architecture program to create a unified data exchange between the state government, health records systems, other data exchange networks and health care providers, including for the Medi-Cal program. Funds would also be used to provide grants and technical support to small provider practices, community health centers and safety net hospitals to expand the use of health information technology and connect to exchanges. | **03/24/2021**<br>Passed Senate Health Committee; referred to Senate Appropriations Committee<br><br>**02/10/2021**<br>Introduced | CalOptima: Watch |
| **RN 21 08473**<br>**Trailer Bill** | **Delayed Proposition 56 Suspensions:** Would delay the suspension of certain value-based payment (VBP) programs authorized under Proposition 56, which are currently set to expire on July 1, 2021. For VBP programs aimed at improving behavioral health integration, DHCS would suspend payments after spending a total of $95 million. For all other VBP programs, DHCS would suspend payments on July 1, 2022. | **02/04/2021**<br>Published on the Department of Finance website | CalOptima: Watch |

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# OLDER ADULT SERVICES

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **H.R. 1868 Yarmuth** | **Extension of Medicare Sequestration Moratorium:** Would extend the moratorium on automatic, across-the-board 2% spending cuts to Medicare payments. The moratorium, which is currently set to expire on March 31, 2021, would end on December 31, 2021. | **03/25/2021** Amended; passed the Senate<br><br>**03/19/2021** Passed the House<br><br>**03/12/2021** Introduced | CalOptima: Watch |
| **AB 523 Nazarian** | **Program of All-Inclusive Care for the Elderly (PACE) Flexibilities:** Would make permanent specified PACE program flexibilities instituted, on or before January 1, 2021, in response to the state of emergency caused by COVID-19 public health emergency. | **04/06/2021** Passed Assembly Aging and Long-Term Care Committee; referred to Assembly Health Committee<br><br>**02/10/2021** Introduced | CalOptima: Watch<br>CalPACE: Support/ Sponsor |
| **AB 540 Petrie-Norris** | **PACE Enrollment Process:** Would seek to increase enrollment for PACE organizations. However, this would:<br>■ Exempt current PACE participants from enrolling in a Medi-Cal MCP;<br>■ Permit PACE to be listed as a Medi-Cal/Medicare plan choice, similar to the existing two-plan model;<br>■ Delay mandatory or passive enrollment into MCPs by up to 60 days for new Medi-Cal beneficiaries age 55 and over or who express interest in PACE; and<br>■ Require DHCS to establish an auto-referral program for those who may be eligible for PACE upon Medi-Cal enrollment. | **04/06/2021** Passed Assembly Aging and Long-Term Care Committee; referred to Assembly Health Committee<br><br>**02/10/2021** Introduced | CalOptima: Watch<br>CalPACE: Support/ Sponsor |
| **AB 911 Nazarian** | **Master Plan on Aging LTSS:** Similar to SB 515, would establish the California LTSS Benefits Board, which would be required to establish a subcommittee to provide ongoing recommendations for the Master Plan on Aging. | **02/25/2021** Referred to Assembly Aging and Long-Term Care Committee and Assembly Human Services Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch |
| **AB 1083 Nazarian** | **Senior Affordable Housing Nursing Pilot Program:** Would require the California Department of Aging to establish and administer the Housing Plus Services Nursing Pilot Program in the counties of Los Angeles, Orange, Riverside, Sacramento and Sonoma. The program would provide grant funds to qualified nonprofit organizations that specialize in resident services for the purpose of hiring one full-time registered nurse to work at three senior citizen housing developments in each county. The registered nurse would be required to provide health education, navigation, coaching and care to residents. | **03/04/2021** Referred to Assembly Aging and Long-Term Care Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **SB 515 Pan** | **Master Plan on Aging LTSS:** Similar to AB 911, would establish the California LTSS Benefits Board, which would be required to establish a subcommittee to provide ongoing recommendations for the Master Plan on Aging. | **02/25/2021** Referred to Senate Human Services Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch |

# PHARMACY

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 671 Wood** | **Disease Management Payment for Specialty Drugs:** Would require DHCS to provide a supplemental disease management payment to contracted pharmacies for dispensing specialty drugs to ensure beneficiary access. | **03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/12/2021** Introduced | CalOptima: Watch |

# PROVIDERS

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 278 Flora** | **Medi-Cal Enrollment for Podiatrists:** Would apply current Medi-Cal provider enrollment processes for a physician to a doctor of podiatric medicine. This would require DHCS to process applications from podiatrists within 90 days instead of 180 days as well as allow podiatrists to use the short form application and change of location options. | **03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**01/19/2021** Introduced | CalOptima: Watch |
| **AB 882 Gray** | **Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program:** Effective January 1, 2022, would restrict eligibility for loan payment assistance under the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which is currently available to recently graduated physicians and dentists who serve Medi-Cal beneficiaries, to only those who practice in federally designated health professional shortage areas and whose patients include at least 30% Medi-Cal beneficiaries. Would indefinitely extend the program beyond its current termination date of January 1, 2026. | **04/06/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch<br>LHPC: Oppose Unless Amended |
| **SB 365 Caballero** | **Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would require Medi-Cal reimbursement for any specialist provider, including a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), who provides an e-consult service to a requesting provider treating a Medi-Cal beneficiary. This may include assessing health records, providing feedback and/or recommending a further course of action. | **03/24/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee<br><br>**02/10/2021** Introduced | CalOptima: Watch<br>LHPC: Support |

## REIMBURSEMENT RATES

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 265**<br>**Petrie-Norris** | **Laboratory Services Reimbursement:** Would remove the current requirement that DHCS cannot reimburse Medi-Cal fee-for-service providers for clinical laboratory or laboratory services at a rate that exceeds 80% of the lowest maximum allowance established by the federal Medicare program for the same service. Federal legislation enacted in 2018 established new Medicare rates for lab services, which resulted in automatic cuts to Medi-Cal reimbursement rates that are now often below the cost of service. | **03/23/2021**<br>Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**01/15/2021**<br>Introduced | CalOptima: Watch |
| **SB 316**<br>**Eggman** | **FQHC Reimbursement:** Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that does not allow an FQHC to be reimbursed for mental or dental and physical health visits on the same day; a patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit (through the member's primary care provider) and a mental health or dental visit as two separate visits, regardless of whether the visits were at the same location on the same day. As a result, a patient would no longer be required to wait for 24 hours between medical and dental or mental health services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC. | **03/22/2021**<br>Passed Senate Appropriations Committee<br><br>**03/10/2021**<br>Passed Senate Health Committee<br><br>**02/04/2021**<br>Introduced | CalOptima: Watch<br>CAHP: Support<br>LHPC: Support |

## SOCIAL DETERMINANTS OF HEALTH

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 71**<br>**Rivas, Luz** | **Bring California Home Act:** Would create the Bring California Home Fund in the State Treasury to fund a statewide homelessness solutions program. Funds would be derived from specified rate increases and other adjustments in the personal income tax and corporate income tax structures. Would authorize the Homeless Coordinating and Financing Council to administer the funds to applicants, including counties and large cities, for the purpose of reducing the number of individuals experiencing homelessness. Eligible uses of funding would include rental assistance, landlord incentives, housing navigation services, moving support, operating costs of affordable supportive and transitional housing projects, and the board and care of individuals with complex needs at licensed residential facilities. | **03/25/2021**<br>Amended; re-referred to Assembly Revenue and Taxation Committee<br><br>**12/07/2020**<br>Introduced | CalOptima: Watch |
| **AB 362**<br>**Quirk-Silva** | **Homeless Shelter Safety:** Would authorize a local health agency to inspect homeless shelters quarterly (and upon suspicion) and enforce new minimum health and safety standards, including those relating to on-site laundry, heating and cooling equipment, lighting, bathrooms, and bedding. | **03/18/2021**<br>Amended; re-referred to Assembly Housing and Community Development Committee<br><br>**02/01/2021**<br>Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 368 Bonta** | **Medically Supportive Food Prescription Pilot Program:** Would establish two-year pilot programs — in the County of Alameda and two other counties with more than 700,000 residents — that provide medically supportive food prescriptions to Medi-Cal beneficiaries with specific chronic health conditions, including depression, Type 2 diabetes, liver disease, high blood pressure, high cholesterol or high body mass index, as a way to help prevent or treat those conditions. Medi-Cal MCPs or their contractors would implement the pilot programs in the participating counties. | **03/18/2021** Amended; re-referred to Assembly Health Committee<br><br>**02/01/2021** Introduced | CalOptima: Watch |
| **AB 369 Kamlager** | **Presumptive Eligibility and Street Medicine Payment:** Would require DHCS to apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Would allow any Medi-Cal provider to determine presumptive eligibility and issue a temporary Medi-Cal card to such individuals, but providers would not be required to verify identity at the time of service. Would also allow Medi-Cal providers to receive reimbursement for any covered Medi-Cal benefit delivered to a homeless individual outside of a medical facility. Further, any Medi-Cal provider could deliver primary care services or refer such individual to a specialist. Upon final determination of eligibility, a homeless individual would be enrolled in Medi-Cal fee-for-service unless he or she chooses to enroll in a Medi-Cal MCP at any time.<br><br>Additionally, would prohibit DHCS from requiring prior authorization or other utilization management of any services related to COVID-19, including testing, treatment, and prevention, through January 1, 2026. | **03/18/2021** Amended; re-referred to Assembly Health Committee<br><br>**02/01/2021** Introduced | CalOptima: Watch |
| **AB 1009 Bloom** | **Farm to School Food Hub Program:** Would establish the Farm to School Hub Program within the California Department of Food and Agriculture. The program would incentivize the creation of third-party "farm to food hubs" to distribute food from local or regional farms to public schools, food banks, and other public and nonprofit organizations. Planning grants of $150,000 each would be distributed to nine hubs across California by December 15, 2022; development grants ranging from $1 million to $5 million each for ongoing capital and operating expenses over a five-year period would be awarded to three hubs by December 31, 2023. | **03/30/2021** Amended; re-referred to Assembly Agriculture Committee<br><br>**02/18/2021** Introduced | CalOptima: Watch |
| **AB 1372 Muratsuchi** | **Temporary Shelters:** Would require every city or county to provide every person who is experiencing homelessness with temporary shelter, access to mental treatment, and resources for job placement and training until the individual is placed in permanent housing. If the use of a temporary shelter is unavailable, that city or county would be required to provide a rent subsidy to that individual. | **03/04/2021** Referred to Assembly Housing and Community Development Committee and Assembly Judiciary Committee<br><br>**02/19/2021** Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **SB 17**<br>**Pan** | **Office of Racial Equity:** Effective until January 1, 2029, would establish the independent Office of Racial Equity to develop a Racial Equity Framework containing guidelines and strategies for advancing racial equity across the state government by January 1, 2023. Each state agency, including DHCS, would be required to implement a Racial Equity Plan by July 1, 2023, in alignment with the goals of the framework, and the office and each agency would prepare annual reports outlining progress toward achieving those goals. | **04/05/2021**<br>Amended; re-referred to Senate Judiciary Committee<br><br>**03/23/2021**<br>Passed Senate Governmental Organization Committee<br><br>**12/07/2020**<br>Introduced | CalOptima: Watch |

# TELEHEALTH

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **H.R. 366**<br>**Thompson (CA)** | **Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would permit the U.S. Secretary of Health and Human Services to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions. | **01/19/2021**<br>Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee | CalOptima: Watch |
| **H.R. 2166**<br>**Sewell** | **Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Similar to S. 150, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. | **03/23/2021**<br>Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee | CalOptima: Watch<br>NPA: Support |
| **S. 150**<br>**Cortez Masto** | **Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Similar to H.R. 2166, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA and PACE plans during the COVID-19 public health emergency. | **02/02/2021**<br>Introduced; referred to Senate Finance Committee | CalOptima: Watch<br>NPA: Support |
| **AB 32**<br>**Aguiar-Curry** | **Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal MCPs, including County Organized Health Systems, to reimburse its contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal MCP, such as contracted health networks. Likewise, clinics must be reimbursed by Medi-Cal for telehealth services at the same rate as in-person services. Would also allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services.<br><br>Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic. DHCS would be required to establish an advisory group to guide the development a long-term Medi-Cal telehealth policy. | **02/12/2021**<br>Amended; re-referred to Assembly Health Committee<br><br>**12/07/2020**<br>Introduced | CalOptima: Watch |

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 935 Maienschein** | **Behavioral Health Telehealth Consultation Program:** Would create a provider-to-provider telehealth consultation program for use when assessing mental health and/or providing mental health treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2022. Would permit telehealth services to be conducted by video or audio-only calls. Additionally, would require the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would require access to a psychiatrist when deemed appropriate or requested by the treating provider. | **02/25/2021** Referred to Assembly Health Committee<br><br>**02/17/2021** Introduced | CalOptima: Watch<br>LHPC: Oppose Unless Amended |
| **RN 21 08394 Trailer Bill** | **Medi-Cal Telehealth Proposal:** Would modify, extend or expand certain telehealth flexibilities adopted by DHCS during the COVID-19 pandemic to be incorporated into permanent law. Would allow FQHCs and RHCs to establish a patient within its federal designated service area through audio-visual telehealth. However, health care providers would be prohibited from establishing a patient through audio-only telehealth or other non-audio-visual telehealth modalities.<br><br>Would also require DHCS to specify the Medi-Cal-covered health care benefits that may be delivered through telehealth services. DHCS and Medi-Cal MCPs would be required to reimburse audio-visual telehealth services at the same rate as in-person services, while audio-only, remote patient monitoring and other modalities may be reimbursed at different rates.<br><br>Additionally, would allow Medi-Cal MCPs to include telehealth services when determining compliance with network adequacy standards without the use of alternative access standard requests. | **02/02/2021** Published on the Department of Finance website | CalOptima: Watch |

# YOUTH SERVICES

| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **H.R. 66 Buchanan** | **CARING for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. | **01/04/2021** Introduced; referred to House Energy and Commerce Committee | CalOptima: Watch |
| **AB 382 Kamlager** | **Whole Child Model (WCM) Program Stakeholder Advisory Group:** Would extend the duration of the California Children's Services Advisory Group, which is currently scheduled to end on December 31, 2021, for an additional two years through December 31, 2023. | **03/23/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee<br><br>**02/02/2021** Introduced | CalOptima: Watch |

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| Bill Number (Author) | Bill Summary | Bill Status | Position/Notes* |
|---|---|---|---|
| **AB 393 Reyes** | **Early Childhood Development Act of 2020:** Effective immediately, would require the California Department of Social Services (CDSS) to conduct an evaluation of emergency childhood services provided during the COVID-19 public health emergency, including the following:<br>■ Availability of crisis childcare services<br>■ Availability of COVID-19 testing and personal protective equipment<br>■ Vaccination prioritization and distribution<br>■ Cleaning of childcare centers<br>■ Payment to family childcare homes during state-mandated closures<br>■ Foster care programs<br>CDSS would be required to submit its findings and associated recommendations to the State Legislature by October 1, 2021. | **02/12/2021**<br>Referred to Assembly Human Services Committee<br>**02/02/2021**<br>Introduced | CalOptima: Watch |
| **AB 1117 Wicks** | **Healthy Start: Toxic Stress and Trauma Resiliency for Children Program:** Would establish the Healthy Start: Toxic Stress and Trauma Resiliency for Children Program (Program). The Program would award grants to qualifying schools, LEAs and other entities serving students, to fund support services for students and their families. Grants awarded would be for no more than $500,000 each and matched by the grantee with $1 for each $2 awarded. Would also require the State Department of Education and DHCS to establish the Children's Coordinated Services Response Team to encourage the integration of children's services at the local level and to promote community resiliency. | **03/04/2021**<br>Referred to Assembly Education Committee and Assembly Health Committee<br>**02/18/2021**<br>Introduced | CalOptima: Watch |
| **SB 428 Hurtado** | **Adverse Childhood Experiences Screenings (ACEs):** Would require a health plan to provide coverage for ACEs. | **02/25/2021**<br>Referred to Senate Health Committee<br>**02/12/2021**<br>Introduced | CalOptima: Watch |
| **SB 682 Rubio** | **Childhood Chronic Health Conditions:** Would require CHHS, the Governor's office and other departments to develop and implement a plan that reduces racial disparities in children with chronic health conditions by 50% by 2030. Chronic conditions may include asthma, diabetes, depression and vaping-related diseases. | **04/07/2021**<br>Passed Senate Health Committee; referred to Senate Appropriations Committee<br>**02/19/2021**<br>Introduced | CalOptima: Watch |

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

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

Last Updated: April 12, 2021

## 2021 Federal Legislative Dates

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

## 2021 State Legislative Dates*

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

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

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

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## About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

# Board of Directors Meeting
# May 6, 2021

## CalOptima Community Outreach Summary — April and May 2021

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

CalOptima's participation in public activities support:
- Member interaction/enrollment in a CalOptima program
- Branding that promotes community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima is following all local, state, and federal guidelines to help mitigate the spread of COVID-19 and as such, is not attending in-person meetings and in-person public activities. CalOptima staff continues to participate in public activities via virtual meetings and events, providing educational materials on CalOptima's programs and, if criteria are met, providing financial support and/or CalOptima-branded items.

**CalOptima Highlights**
CalOptima hosted a virtual Brown Bag Lunch and Learn on Tuesday, April 20, 2021 from Noon–1 p.m. The event focused on "Community Resources to Support Veterans and Military Families" and was open to CalOptima staff and our health care partners.

The goal for this virtual event was to increase understanding of what it means to be "service-connected," the various sectors of the military, and the unique needs of this population. There were feature presentations from Child Guidance Center Strong Families and Strong Children, Volunteers of America, and the Goodwill of Orange County's Tierney Center for Veteran Services. Attendees had the opportunity to learn about comprehensive services provided by these organizations, including case management, employment services, housing support, and mental health services and supports.

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

**Summary of Public Activities**
As of April 5, 2021, CalOptima expected to participate in, organize, or convene 66 public activities in April and May. In April, these included 37 public activities: 27 virtual community/collaborative meetings; 4 community events; 4 community-based organization presentations; 1 CalOptima Health Network Forum; and 1 Cafecito meeting.

In May, there will be 30 public activities: 23 virtual community/collaborative meetings; 4 virtual community events; 1 community-based organization presentation; 1 Community Alliances Forum and 1 CalOptima Health Network Forum.

Below are more details about CalOptima's expected participation in these community and CalOptima hosted events.

## April 2021

| Date/Time | Event Title/Location | Expected Staff/Volunteer/Financial Participation | Event Type/Audience |
|---|---|---|---|
| 4/3<br>9 a.m.–12 p.m. | **Drive-Through Egg Hunt hosted by the City of Cypress†**<br>City of Cypress Recreation Center at 5700 Orange Ave., Cypress | 0 staff to attend<br>Sponsorship fee: $150 includes CalOptima's flier in 800 attendees' bags and CalOptima featured as sponsor on event webpage and signage. | • Conference<br>• Open to health and human service providers; registration required |
| 4/3<br>11 a.m.–1:15 p.m. | **Spring Fling: Health and Resource Fair hosted by Grandma's House of Hope†**<br>The Crossing at Cherry Orchard at 2748 W. Lincoln Ave., Anaheim | 0 staff to attend<br>Sponsorship fee: $700 includes a resource table staffed by volunteers provided by event host to distribute CalOptima's literature and branded items, recognition of sponsorship during the event and placement of CalOptima's logo on host's website and social media channels. | • Health/resource fair<br>• Open to residents |
| 4/14<br>2–3 p.m. | **CalOptima Medi-Cal Presentation for Benito Juarez Elementary School Parents***<br>Virtual | 1 staff to present | • Community-based organization presentation<br>• Open to parents |
| 4/15<br>9–11 a.m. | **Health Network Forum***<br>Virtual | 10+ staff to attend | • Forum<br>• Open to health and human service providers |
| 4/15<br>2–3 p.m. | **CalOptima Medi-Cal Presentation for Benito Juarez Elementary School Parents***<br>Virtual | 1 staff to present | • Community-based organization presentation<br>• Open to parents |
| 4/20<br>12–1 p.m. | **CalOptima Brown Bag Lunch and Learn—Topic: Community Resources to Support Military Families and Veterans***<br>Virtual | 40+ staff to attend | • Community-based organization presentation<br>• Open to health and human service providers; registration required |
| 4/21<br>3:30–4:30 p.m. | **CalOptima Medi-Cal Presentation for Orange County School Nurses Organization***<br>Virtual | 2 staff to present | • Community-based organization presentation<br>• Open to members of the organization |
| 4/22<br>2–3:30 p.m. | **A Wellness Event hosted by the Orange County Department of Education†**<br>Virtual | 2 staff to present | • Health/resource fair<br>• Open to the public |
| 4/22<br>4:30–5:15 p.m. | **Roadmap to Success hosted by the Garden Grove Unified School District†**<br>Virtual | 1 staff to present | • Health/resource fair<br>• Open to the public |
| 4/28<br>9–10:30 a.m. | **Cafecito Meeting***<br>Virtual | 3+ staff to attend | • Steering committee meeting<br>• Open to collaborative members |

* CalOptima Hosted
† Exhibitor/Attendee

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| May 2021 | | | |
|---|---|---|---|
| 5/1–5/31<br>8 a.m. and at 6 p.m. | **South County Senior Summit hosted by Age Well Senior Services and partners†**<br>Virtual | 1 staff to present<br>Sponsorship fee: $10,000 includes a 10-minute speaking opportunity featuring CalOptima COVID-19 animated 'explainer' video, placement of CalOptima's logo on all event marketing and direct mailers (150,000+ oversized postcards mailed to South County households and 200,000+ digital fliers to South County residents); and recognition of sponsorship during pre-recorded event. | • Health/resource fair<br>• Open to the public |
| 5/6<br>10 a.m.–12:30 p.m. | **OC Youth Service Providers Consortium hosted by Laura's House and partners†**<br>Virtual | 3+ staff to attend | • Conference<br>• Open to health and human service providers; registration required |
| 5/11<br>9–11 a.m. | **Community Alliance Forum–COVID-19 Update, Vaccines and Addressing Barriers for Health Equity**<br>Virtual | 40+ staff to attend | • Forum<br>• Open to health and human service providers |
| 5/12<br>1–2 p.m. | **CalOptima Medi-Cal Presentation for Orange County Asian Pacific Islander Community Alliance***<br>Virtual | 1 staff to present | • Community-based organization presentation<br>• Open to service providers |
| 5/19–5/20<br>8:30 a.m.–1 p.m. | **Annual Conference hosted by Families and Communities Together of Orange County†**<br>Virtual | 5+ staff to attend<br>Sponsorship fee: $1,000 includes recognition as a sponsor during the event; 5 conference admissions; and opportunity to share resources during event. | • Conference<br>• Open to health and human service providers; registration required |
| 5/20<br>9–11 a.m. | **Health Network Forum***<br>Virtual | 10+ staff to attend | • Forum<br>• Open to health and human service providers |
| 5/25–5/27<br>8 a.m.–1:30 p.m. | **Annual Virtual Health Literacy Conference hosted by Institute for Healthcare Advancement†**<br>Virtual | 2+ staff to attend<br>Sponsorship fee: $1,000 includes a virtual exhibit booth; visual acknowledgment of CalOptima's support during opening & closing sessions; CalOptima-branded item in the conference digital tote bag; one-time e-blast to pre-registration list; placement of CalOptima logo on a banner ad throughout the conference (4x) and digital tote bag. | • Conference<br>• Open to health and human service providers; registration required |

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

Sponsorship requests must align with CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

**Endorsements**
CalOptima provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsements must align with CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about

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

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

13. Consider Adopting Resolutions Authorizing the Appointment of Retired Annuitants to Carry out the Duties and Responsibilities of Medical Directors During the Recruitment to Permanently Fill Vacancies and Ensure Continuity of Services and Prevent the Stoppage of Public Business

**Contacts**

Emily Fonda, Chief Medical Officer, (714) 246-8887
Brigette Gibb, Executive Director, Human Resources, (714) 246-8405

**Recommended Actions**

1. Adopt Resolution No. 21-0506-02 of- annuitant in accordance with Government Code sections 7522.56 and 21221(h), and certifying the nature of the employment of Dr. Donald Sharps;
2. Authorize the Chief Executive Officer (CEO) to approve and appoint Dr. Donald Sharps prior to the 180-day waiting period as an interim appointment retired annuitant to the vacant position of Medical Director;
3. Adopt Resolution No. 21-0506-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222(h) and certifying the nature of the employment of Dr. Richard Helmer;
4. Authorize the CEO to approve and appoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Medical Director;
5. Authorize the CEO, or his designee, to continue the current search for permanent Medical Directors; and
6. Authorize unbudgeted expenditures in an amount up to $71,654 from unspent budgeted funds in the FY2020-21 budget to support the recommended interim appointments through June 30, 2021.

**Background/Discussion**

CalOptima has a total of seven Medical Director positions, with each accountable for different areas of responsibility. With two Medical Directors separating in the last two months, CalOptima's medical team is understaffed, with four of the seven positions currently vacant. Additionally, the Deputy Chief Medical Officer position is also vacant. These circumstances, compounded by the COVID-19 pandemic, highlight that CalOptima does not currently have sufficient medical professionals on staff to fill the roles and responsibilities of the two newly vacated positions while recruitment efforts continue to fill the five vacant Medical Director positions.

With the retirement of Medical Director Dr. Donald Sharps on March 26, 2021, a vacancy was created in the Behavioral Health Integration (BHI) department. The work performed by the BHI Medical Director is critical to CalOptima's successful operations and must continue while CalOptima recruits to fill the vacancy. The role of the BHI Medical Director is significant. It includes providing oversight, monitoring regulatory compliance, directing utilization reviews, quality and case management, health education, and grievance & appeals activities, assisting with the development and implementation of the California Advancing & Innovating Medi-Cal (CalAIM) program, and collaborating with the County of Orange and Organized Delivery System Drug Medi-Cal (ODS-DMC) (Attachment 3).

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Other than Dr. Sharps, no current or former CalOptima Medical Directors possess the licensure, knowledge, and experience to oversee BHI immediately. Having been in the role of the BHI Medical Director position since the inception of the BHI program, Dr. Sharps is the most qualified individual to fill this unique and critical position during the recruitment process and before 180 days has passed since his separation (Attachment 4).

Separately, the Medical Director responsible for PACE, Quality and Population Health (PACE Medical Director) separated from CalOptima on April 6, 2021. This created a vacancy \in the PACE department. The work performed by the PACE Medical Director is critical to the successful operation of PACE and must continue while CalOptima recruits to fill the vacancy. This Medical Director is responsible for providing clinical leadership to PACE and participates in the development and implementation of the PACE program, including policies and procedures for clinical services and the quality assurance program initiatives (QAPI). The position is also responsible for overseeing the clinical care provided by the CalOptima PACE program and ensuring quality clinical service delivery to PACE participants. The position is also responsible for providing oversight of the physicians, nurse practitioners, pharmacists, and other PACE staff (Attachment 7).

Having previously served in the role of Chief Medical Officer for CalOptima from May 7, 2013 until his retirement on October 1, 2018, Dr. Helmer has insight and knowledge regarding CalOptima's PACE operations. Dr. Helmer meets all the requirements of the position and is qualified to fill the unique Medical Director position at PACE during the recruitment process (Attachment 8).

A retired annuitant is a CalPERS retiree who works as an at-will employee for a CalPERS employer with certain restrictions to avoid jeopardizing his or her retirement allowance (pension payments). CalPERS has requirements that must be met to allow a retired annuitant to work for a CalPERS employer without reinstatement. One of these requirements is a 180-day wait period after retirement. Dr. Helmer has met the 180-day wait period. Dr Sharps has not. However, an exception may be made if the governing body adopts a resolution consistent with Government Code sections 7522.56 & 21221(h) to waive the waiting period for separation and allow the retired annuitant to perform work of limited duration before the 180-day wait period has passed.

Retired annuitants do not accrue service credit or otherwise acquire any additional retirement benefits from the employment. The retired annuitant restrictions for interim appointment positions are authorized by Government Code sections 7522.56 and 21221(h). As retired annuitants, both Dr. Helmer and Dr. Sharps will each be limited to no more than 960 work hours per fiscal year. It is anticipated that the interim appointments will last no longer than twelve (12) months. The attached Resolutions meet all requirements set forth by CalPERS.

In addition, appointments to interim positions by the CalOptima Board of Directors, as authorized by Government Code sections 7522.56 and 21221(h) requires that before the retired annuitants are hired, the employer must have in place an active recruitment for a permanent replacement for the vacant positions. All Medical Director positions, including for PACE and BHI, are posted for active recruitment for permanent replacements. The attached offer letters appointing Dr. Sharps and Dr.

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Helmer to the interim appointment retired annuitant positions along with the adoption of the two resolutions and recommended Board actions meet all the requirements for interim appointments.

**Fiscal Impact**

The fiscal impact for the interim appointments for the period May 23, 2021, through June 30, 2021, is $71,654, and will be budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget on June 4, 2020, will fund this action.

The annualized fiscal impact for the two interim appointments is $305,722. Management will include expenses related to the interim appointments in the upcoming FY 2021-22 Operating Budget.

**Rationale for Recommendation**

The recommended actions to appoint Dr. Sharps and Dr. Helmer as Medical Directors will enable critical oversight of the BHI and PACE Departments by two uniquely qualified doctors and will ensure minimal interruption in business operations while recruitments to fill the positions permanently are underway.

**Attachments**

1. Resolution No. 21-0506-02 approving an exception to the 180-day waiting period, authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code sections 7522.56 and 21221(h), and certifying the nature of the employment of Dr. Donald Sharps
2. Offer Letter for Dr. Donald Sharps
3. Job Description for Medical Director, Behavioral Health Integration
4. Resume for Dr. Donald Sharps
5. Resolution No. 21-0506-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222(h) and certifying the nature of the employment of Dr. Richard Helmer
6. Offer Letter for Dr. Richard Helmer
7. Job Description for Medical Director, PACE, QI and Population Health
8. Resume for Dr. Richard Helmer
9. Gov Code 7522.56
10. Gov Code 21221(h)
11. CalOptima Salary Schedule Attachment A to CalOptima Policy GA.8058 (effective March 14, 2021)
12. Job Posting for Medical Director, Behavioral Health Integration
13. Job Posting for Medical Director, PACE, QI and Population Health

**Concurrence**

Gary Crockett, Chief Counsel

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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# RESOLUTION NO. 21-0506-02

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

**APPROVING AN EXCEPTION TO THE 180-DAY WAITING PERIOD, AUTHORIZING THE HIRING OF A CALPERS RETIRED ANNUITANT IN ACCORDANCE WITH TO MEDICAL DIRECTOR PER GOVERNMENT CODE SECTIONS 7522.56 & 21221(h) , AND CERTIFYING THE NATURE OF THE EMPLOYMENT OF DR. DONALD SHARPS**

**WHEREAS**, in compliance with Government (Gov.) Code section 7522.56 of the Public Employees' Retirement Law, the CalOptima Board of Directors must provide CalPERS this certification resolution when hiring a retiree before 180 days has passed since their retirement date; and

**WHEREAS**, Dr. Donald Sharps, CalPERS ID - 6770298906 retired from CalOptima in the position of Medical Director, Behavioral Health Integration, effective March 26, 2021; and

**WHEREAS**, Gov. Code section 7522.56 requires that post-retirement employment commence no earlier than 180 days after the retirement date, which is September 23, 2021, without this certification resolution; and

**WHEREAS**, Gov. Code section 7522.56 provides that this exception to the 180-day wait period shall not apply if the retiree accepts any retirement-related incentive; and

**WHEREAS**, the CalOptima Board of Directors, CalOptima, and Dr. Donald Sharps certify that Dr. Donald Sharps has not and will not receive a Golden Handshake or any other retirement-related incentive; and

**WHEREAS**, an appointment under Gov. Code section 21221(h) requires that the retiree is appointed into the interim appointment during recruitment for a permanent appointment; and

**WHEREAS**, the governing body has authorized the search for a permanent appointment on May 6, 2021; and

**WHEREAS**, the CalOptima Board of Directors hereby appoints Dr. Donald Sharps as an interim appointment retired annuitant to the vacant position of Medical Director, Behavioral Health Integration for CalOptima under Gov. Code section 21221(h), effective May 23, 2021; and

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**WHEREAS**, this Gov. Code section 21221(h) appointment shall only be made once and therefore will end on or before June 30, 2022; and

**WHEREAS**, the entire employment appointment document between Dr. Donald Sharps and CalOptima has been reviewed by this body and is attached herein; and

**WHEREAS**, no matters, issues, terms or conditions related to this employment and appointment have been or will be placed on a consent calendar; and

**WHEREAS**, the employment shall be limited to 960 hours per fiscal year for all CalPERS employers; and

**WHEREAS**, the compensation paid to retirees cannot be less than the minimum nor exceed the maximum monthly base salary paid to other employees performing comparable duties, divided by 173.333 to equal the hourly rate; and

**WHEREAS**, the maximum monthly base salary for this position is $27,600, and the hourly equivalent is $159.23, and the minimum monthly base salary for this position is $18,450, and the hourly equivalent is $106.44; and

**WHEREAS**, the hourly rate paid to Dr. Donald Sharps will be $159.23; and

**WHEREAS**, Dr. Donald Sharps has not and will not receive any other benefit, incentive, compensation in lieu of benefit or other form of compensation in addition to this hourly pay rate; and

**NOW, THEREFORE, BE IT RESOLVED**:

That the CalOptima Board of Directors hereby certifies the nature of the employment of Dr. Donald Sharps as described herein and detailed in the attached employment appointment document and that this appointment is necessary to fill the critically needed position of Medical Director, Behavioral Health Integration-(BHI Medical Director) for CalOptima by May 23, 2021 because the work performed by the BHI Medical Director is critical to the successful operation of this Medi-Cal required behavioral health benefit and must continue while CalOptima recruits to fill the vacancy, in order to: provide oversight; monitor regulatory compliance; direct utilization reviews, quality and case management, health education, and grievance & appeals activities; assist with the development and eventual implementation of the California Advancing & Innovating Medi-Cal (CalAIM) program; and collaborate with the County of Orange and the Organized Delivery System Drug Medi-Cal (ODS-DMC). No other CalOptima Medical Directors, current or previously employed, possesses the knowledge and experience to oversee BHI immediately. Having been in the role of the BHI

Medical Director position since the inception of the BHI program, Dr. Sharps is the most qualified individual to fill the gap during the recruitment process.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this May 6, 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

Attest:

/s/_______________________________________
Sharon Dwiers, Clerk of the Board

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May __, 2021

Donald Sharps, M.D.

Dear Donald,

It is my pleasure to confirm to you an offer of temporary employment as an As-Needed, Medical Director – Retired Annuitant, to become effective on May 23, 2021 to end on or before June 30, 2022, or a maximum of 960 hours worked within each fiscal year, or upon the commencement of work by a permanent employee hired into the position, whichever comes first.

You will receive an hourly rate of $159.23 payable according to CalOptima's usual payroll schedule, with appropriate deductions withheld as required under federal, state, and local tax laws. You will also receive reimbursement for pre-approved/reasonable costs and expenses incurred while performing your obligations as a Medical Director in accordance with reimbursement policies established by the CalOptima Board of Directors. As a retired annuitant, you are not eligible to receive employee benefits or holiday pay, and you will not accrue paid time off applicable to permanent employees. In accordance with CalPERS' requirements, a retiree may work up to no more than a total of 960 hours within a fiscal year without reinstatement. It is your responsibility to keep track of the total time worked. As a retiree, you must be enrolled as a retired annuitant and payrate with hours worked reported in the "my|CalPERS" system. No retirement contributions are reported by the employer or member for retired annuitants.

All employment at CalOptima is at-will, which means that either the employee or CalOptima may end the employment relationship at any time, with or without cause. By signing this offer letter, you agree and understand that your employment relationship with CalOptima is at-will with no guarantee of employment for any specified term. By signing this offer letter, you agree that this is the final and full agreement regarding the at-will nature of your employment relationship and cannot be later altered unless the Chief Executive Officer of CalOptima and you sign an agreement to the contrary.

Please be advised that you will be a Designated Employee pursuant to CalOptima's Conflict of Interest Code and therefore subject to its provisions, including the annual filing of California Fair Political Practices Commission Form 700: Statement of Economic Interests. Furthermore, because of the sensitive nature of your job responsibilities with CalOptima, your subsequent employment with an entity contracted to provide services to CalOptima creates a potential conflict of interest. You must therefore agree to notify promptly and in writing the CalOptima CEO and the Chair of the Board of Directors if, up to twelve (12) months after terminating employment with CalOptima, you obtain employment with a CalOptima contractor. You must also agree that, during the twelve months after terminating employment with CalOptima, you will not be directly or indirectly involved in negotiating, servicing, or soliciting contracts with CalOptima for a contractor by whom

you have been employed, or otherwise retained. For one (1) year following separation, you must agree not to actively recruit, solicit, or offer employment to any current CalOptima employee.

I know that with your extensive knowledge and experience, you will bring critical expertise and important perspective that will be of great value to us in this vital position to provide continuity in service during this statewide emergency. I believe that you will find this role rewarding as you assist CalOptima in its important mission to deliver quality, accessible, and efficient health care services to its members. We look forward to a positive and productive working relationship. As verification that you accept this offer, please sign the enclosed copy of this letter and return it to me by [**DATE**].

Sincerely,

Richard Sanchez,
Chief Executive Officer

**UNEMPLOYMENT CERTIFICATION**

By signing below, I hereby certify that I have not received any unemployment insurance payments within the 12 months prior to this appointment and I have not provided previous retired annuitant work with any other CalPERS employer.

Date: ____________________  Accepted: ___________________________
Donald Sharps

Name (Print): ________________________

**ACKNOWLEDGMENT AND ACCEPTANCE**

By signing below, I hereby accept the offer as described in this letter dated [**DATE**] and understand that it is a conditional offer, which can be revoked. I understand that the position is an As-Needed retired annuitant position with no expectation of continuous employment. I understand that it is my responsibility to ensure that my work hours will not exceed 960 hours per fiscal year, and I understand that any violation of the work hours limitation or CalPERS requirements on my part may impact my current retirement with CalPERS.

Date: ____________________

Accepted: ___________________________
Donald Sharps

Name (Print): ________________________

# Medical Director (Behavioral Health)

**Department(s):** Medical Management
**Reports to:** Chief Medical Officer (CMO)
**FLSA status:** Exempt
*Revised: 02/12/2021*

## Job Summary

The Medical Director for Behavioral Health (BH) is responsible for clinical oversight and management of CalOptima's behavioral health activities including, case management, utilization management, quality management, and contracted services.

## Position Responsibilities

- Provides strategic direction for the Behavioral Health Department.
- Provides quality oversight and lead the quality efforts for Behavioral Health.
- Develops and implements medical policies for Behavioral Health.
- Provides direction and control of current medical practices for Behavioral Health ensuring that medical personnel for the plan follow medical protocols and rules of conduct.
- Ensures that medical decisions regarding behavioral health are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Oversees reporting and profiling of behavioral health providers.
- Ensures the appropriate and timely use of criteria and guidelines in the administration of behavioral health treatment.
- Ensures that assigned patients are provided behavioral health services and necessary medical attention at all locations.
- Works with the Contracting department to ensure a full and appropriate primary and specialty behavioral health care provider network for members.
- Consults on written protocol for behavioral health providers to ensure adherence to standards and quality of care. Coordinate professional interactions amongst practitioners and lend assistance toward correcting any deviation from standards. Develop relationships with directly contracted behavioral health providers.
- Participates in the quality management program for behavioral health providers which includes protocol, procedures, oversight, and training in the following areas:
    - Provider selection
    - Credentialing
    - Quality assessment studies
    - Peer review activities

- Referral management
  - Pre-admission authorization
  - Prospective, concurrent and retrospective review
  - Utilization review reporting and evaluation
  - Case management
  - NCQA accreditation
- Reviews State and Federal mandated benefits to ensure CalOptima Behavioral Health is in full compliance through its providers.
- Ensures the privacy and security of Protected Health Information (PHI) as outlined in CalOptima's policies and procedures relating to HIPAA compliance.
- Any other duties as required to ensure the plan operations are successful.
- Other projects and duties as assigned.

## Possesses the Ability To:

- Manage a large point of service network of providers.
- Develop and implement appropriate medical service contracts and monitor compliance.
- Plan, organize, and direct utilization review, quality management, case management, health education, and grievance activities.
- Ensure appropriate and cost-effective medical care and services to members not covered by a contracted health plan.
- Establish and maintain effective interpersonal relationships with all levels of staff, other programs, agencies, and the general public.
- Communicate clearly and concisely, both verbally and in writing.
- Utilize computer and appropriate software (e.g., Microsoft Office: Word, Outlook, Excel, PowerPoint) and job specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

## Experience & Education:

- Current, valid, unrestricted California Physician and Surgeon's License with Board certification in Psychiatry required.
- 5+ years of Medical Administrative experience required.
- Utilization Management experience with expertise in Medi-Cal managed care and Medicare required.

## Preferred Qualifications:

- Sub-specialization or additional training and experience in substance use disorder with understanding of American Society of Addiction Medicine (ASAM) Levels-of-Care with the County Organized Delivery System Drug Medi-Cal (ODS – DMC) preferred.
- Additional training with children including understanding of County Levels-of-Care, Regional Center, and Applied Behavioral Analysis for Autism Spectrum Disorder (ASD), Intellectual Disabilities and other non-ASD diagnoses preferred.
- Expertise in medical program design preferred.

## Knowledge of:

- Electronic Health Records (EHR) typically used by Behavioral Health (BH) provider, Medical Providers, Hospitals and Managed Care.
- Administrative practices and procedures including but not limited to quality assessment and improvement, utilization review, peer review, credentialing, and risk management.
- Rules regulations, policies, and standards related to managed care, including California Department of Health Care Services (DHCS), and California Department of Managed Care Services (DHMS)
- Effective supervision and organization.
- Pay for Value reimbursement and other innovative BH provider reimbursement that focuses on quality.
- Medi-Cal services coordination with Local Education Authorities (LEA)
- Methods, techniques, practices, principles, and literature in Psychiatry including psychopharmacology for formulary and non-formulary medications, other psychiatric treatments including innovative / experimental treatments.
- Methods, techniques, practices, principles, and literature in the broad field of medical sciences and an overview of the highly specialized techniques, procedures and equipment used in the medical or surgical specialists.

## Physical Demands and Work Environment

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* While performing duties of job, employee may be required to move about the organization. Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to communicate, particularly for regular phone use and in meetings. Must have means of transportation, as occasional travel is required.

- *Work Environment:* Typical office environment with minimal to moderate noise levels and controlled office temperatures. Off-site work environment varies depending on location.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

**CURRICULUM VITAE**
**Donald L Sharps, M.D.**

## *DESCRIPTION of LICENSURE and CERTIFICATION*

Board Certified in Psychiatry / Neurology, Certificate #30090 1988 – present

California Medical License #G47508 1982

Guam Medical License #882 1986 (inactive)

Federated States of Micronesia Medical License #319 1987 (inactive)

Diplomate National Board Medical Examiners Parts I, II, III # 240-327 1982

## *MEMBERSHIPS*

American Psychiatric Association Distinguished Fellow

California Psychiatric Association – Chair of Public Psychiatric Committee 2005 to present

Orange County Psychiatric Society (OCPS) President 2004 - 2006

American Society of Addiction Medicine (ASAM)

## *PRIVATE CLINICAL PRACTICE*

South Coast Medical Center – Behavioral & Substance Abuse Recovery Consultant Psychiatrist 2006 - 2009

Western Youth Services Child & Adolescent Psychiatry 2003 - 2006

Private Practice Office - Laguna Niguel & Corona del Mar, CA 1988 - 2002

Guam: FHP consultant & Superior /Federal Court Consultant 1986 - 1988

Private Practice Office - 5220 N Clark Ave Lakewood, CA 90712 1985

## *ADMINISTRATION EXPERIENCE*

Medical Director for CalOptima Behavioral Health Integration 2013 - present

Wellpoint National Formulary Committee / Anthem Physicians Relations Committee 2007 - present

Associate Medical Director for Orange County Health Care Agency Behavioral Health 2002 - 2013

Quality Improvement Psychiatrist for Orange County Health Care Agency 1996

Private Practice Business Management 30131 Town Center #235 Laguna Niguel, CA 92677 1988

Adult Program Director Charter Hospital , Mission Viejo, CA 92691 1993 -1996

Medical Director Guam Dept. Mental Health & Substance Abuse (DMHSA) 1986 - 1988
Awarded *The Ancient Order of the Chamorri* by the Governor of Guam for service to the island

## *HOME*

Two sons – both graduates of MIT

## *TEACHING / ACADEMIC EXPERIENCE since 1985*

University of California Irvine – Professor 2014 - 2020t
University of California Irvine – Assistant Professor 1988 - 1993 & 1998 to 2014

Supervision 3rd & 4th Yr UCI Psychiatry Residents in outpatient community mental health clinic
Lecture / Supervise – year long course in Community Mental Health

Quality Review and Training with Orange County Heath Care Agency 1996 to 2013

National University – Instructor for Master's Program for Mental Health Professionals 1995

University of Hawaii - Clinical Instructor 1986 - 1987

Los Angeles County / University of Southern California Medical Center - Clinical Faculty 1985 - 1986

## *FORENSIC EXPERIENCE*

Expert Medical Examiner State of California 1995 to 2014

American Board of Forensic Medicine & Forensic Examiners, Certificate #6664 1995

College of Forensic Psychiatry 1987

Orange County Superior Court / Federal District Court - Expert Witness

Superior Court of Guam / Federal District Court - Forensic Examiner 1988

Performed over 100 forensic competency-to-stand-trial, competency-to-be-sentenced, and ability-to- understand-and-control-action evaluations. In addition to these criminal evaluations there were multiple civil evaluations for custody cases and management of individuals convicted of sexual abuse.

Los Angeles County / University of Southern California Medical Center 1984

## *ACADEMIC TRAINING (Residency & Internship)*

Psychiatry - Los Angeles County / University of Southern California Medical Center 1985
*Chief Resident 1984 - 1985*

Rotating Ob-Gyn Internship Marshall University at Huntington, West Virginia 1982

Pediatric Internship (half-year) Children's Hospital of Columbus Ohio 1981

## *ACADEMIC TRAINING (Medical School & Undergraduate)*

Ohio State University Medical School - Columbus Ohio 1977 - 1981
Case Western University B.A. - Cleveland Ohio 1977
Chinese University of Hong Kong – Year abroad program (Mandarin Language & Psychology) 1976

## *AWARDS*

Bruno Lima Award – 2006 National APA award for Excellence in Disaster Psychiatry
Thomas Riley Orange County Community Service Award – 2008 Orange County Mental Health Association
Ed Rudin Award – 2009 California Psychiatric Association award for contributions to state government affairs on behalf of Psychiatry

Detailed description of above experiences and references available on request.

## Brief Description of Current Position beginning in November 2013

**Medical Director for CalOptima's Behavioral Health Integration**

The individuals for whom I am providing services includes patients / families, providers, community organizations, and the staff with whom I work. All of these different 'customers' have unique needs and I focus on meeting those needs. I work with others to identify issues and collaboratively seek solutions. I present options, solutions and new ideas to Board members, advisory board members, staff, community members always with an interactive style that incorporates the other person's perspective including social and cultural factors manner. Feedback that I consistently receive is that I have a strong element of engagement that makes my presentations enjoyable and more effective.

I am attentive to the rapidly changing regulatory landscape affecting Behavioral Health (BH) and participate with the state in understanding how to implement programs compliantly and effectively. I am always looking for new ideas and approaches to improve knowledge / skills and the staff's effectiveness in providing compassionate and quality BH care. I am persistently seeking new opportunities to learn about BH treatments following values of accountability, and good stewardship.

I make effective decisions based on the information that I have from clinical, utilization management, and regulatory guidelines. Even when the situation is unable to be clarified by the state, using the best information as well as my experience, I contribute to executive and strategic decisions. The input of key individuals is consistently utilized, and after decisions are made, decisions are communicated in a manner to assure the comprehension and acceptance by others.

**Duties** have included:

- Mental health & substance abuse Medical Direction for Medi-Cal Managed Care Network with over 700,000 members through a delegated NCQA MBHO – launched on time, meeting clinical and regulatory guidelines, in January 2014 with the implementation of the ACA's Medi-Cal Essential Mental Health and Substance Abuse Benefit, which launched. The elements of this responsibility have been:
  - Utilization Management guideline approval and accountability
  - Quality Improvement Committee formation and workgroup measures
  - New BH roles in the DHCS audit, HEDIS Roadmap, NCQA audit prep
  - New BH roles SPD Model of Care with ICT participation
  - Delegation of agreement updates and coordination with Oversight Committee
  - Coordination of Care between PCP and MH (eg utilizing screening tool and updated MOU).
  - Oversight of Administrative Services Organization (ASO) - while I was the County' BH Medical Director, I had participated in the initial ASO contract. The ASO provided three services: Access Line (eligibility, assessment, CSI and initial authorization), Network of Psychiatrists (including credentialing), Claims (including all non-preauthorized psychiatric inpatient)

- Mental health and substance abuse Medical Direction for Medi-medi (dual-eligibles) pilot program (CalMedi Connect Managed Care Network through delegated MBHO
  - Medical / psychiatric oversight in the CMS audit, and mock CMS audits
  - Utilization Management oversight with CMS Local Coverage Determinations
  - Revamping 'dashboard' for the Quality Improvement Committee, and Compliance
  - Developed Health Risk Assessment HRA development
  - Implementing the new roles in the Model of Care with ICT participation
  - Delegation of agreement updates and coordination

- Coordination of Care between the County's SPMI and CalMedi Connect
- Preparation for OneCare Connect
- Finalizing the P&Ps and the required contract ( MOU) for Dual's project with the County MHP
- Provided the claims business-rule template for the reimbursement decision-making

- Supervision & case management with nurses, and social workers
  - Continuously provided clinical and administrative supervision for the newly hired and trained managers and clinicians
  - Direct modeling of interactions with the delegated entities, community agencies, and intraagency departments
  - Information that I provide the staff is a reflection of my understanding, and the requests that are made to the staff have measurable and achievable goals
  - Daily involvement with medical case management staff regarding patients with significant medical problems and behavioral health issues

- BH QI data collection and reporting involve my BH QI quarterly meeting
  - Reports to the central QI meeting
  - Minutes clearly reflect the community providers' discussion regarding opportunities for improvement that are consistent with NCQA and HEDIS

- Pharmacy Triage Consultation regarding overuse, misuse, polypharmacy
  - Chairperson for the Pharmacy & Therapeutics Committee for over sixteen years
  - Medical Director of Association for Community Affiliated Plans (ACAP) Substance Abuse Collaborative, I review referrals for audit and investigations

- Launch of new BHT benefit for ASD and Regional Center Transition Plan for BHT/ABA Services
  - Working with case managers to coordinate appropriate and medically necessary MH services for children and adults with Intellectual Disabilities and Autism Spectrum disorders
  - Continue to be involved in the Regional Center Resolutions process (which I did for 17 years as part of the MHP)
  - Planning and implementing the transition of approximately 1000 members from RCOC
  - Addressed reducing backlog for Comprehensive Diagnostic Evaluations (CDE), establish provider rates for six month transition period, approve the three tier model of supervision used by BHT providers, and require ABA documentation in managed care

- Review of quality of care issues with patients' grievances

## Professional Interests

Areas that would allow opportunities for:

- Assuring maintenance of quality clinical practice standards in the systems of care
- Medical administration of System of Care within with a Recovery emphasis
- Medical / psychiatric integration with other medical professionals and services in the community

## Personal Interests

- Family
- Outdoor activities – running, bicycling, hiking, travel
- Reading, theater, cooking

## Medical Director OC HCA until November 2013

**Associate Medical Director for Orange County Health Care Agency Behavioral Health Services**

1996 - full time Quality Improvement & Training Psychiatrist for the 35+ psychiatrists in the county clinics / contract clinics, and utilization review psychiatrist for the contract clinic & Medi-Cal fee-for-service psychiatrists. In 2002, the role was changed to that of Associate Medical Director, with greater focus on clinical direction while continuing with QI oversight.

Associate Medical Director **duties** included:

- Daily clinical supervision & problem solving with psychiatrists, nurses, and social workers
- Supervise Nurse Practitioners
- Supervise PGY-4 UCI residents on full-time rotation in county clinics
- Advise HCA administrative staff on matters pertaining to medical staff and medical issues
- Maintain standards for selection, interviewing, training and retention of psychiatrists
- Regularly scheduled clinic meetings with psychiatrists regarding clinical care and systems function
- Regularly schedule CME programs with clinic psychiatrists developed from demonstrated QI needs
- Training on medical management related to patients with SPMI for county / contract psychiatrists
- Conduct Monthly meeting for OC BH nursing staff / new nursing staff orientation to clinics
- Training on dual diagnosis treatment guidelines for county / contract staff
- Medication monitoring and reporting including QI quantification for DMH
- Medical review of cases transferred from within Levels of Care
- Liaison between Drug and Alcohol Services / Correctional Mental Health / Children's Services
- Review of Treatment Authorization Requests (TAR)
- Regular medical consultation for outpatient managed care staff
- Medical consultation with inpatient managed care, residential services, and emergency services
- Medical consultation on clozapine and ECT cases
- Steering Committee for Medi-Cal Outpatient Consolidation (1997 – 1998)
- Steering Committee for Mental Health Services Act Implementation (2006 – 2009)
- Maintain effective working relationships between the county and various federal, state, and local professional & medical associations
- Represent the county on committees in the community
- Continuing Medical Education Committee Chairperson
- Prescribing Guidelines Committee Chairperson
- Medical consultation for regularly scheduled QIC meetings
- Review of Request for Proposals (RFP) for contract services
- Negotiation of laboratory contracts and establishing guidelines for use in mental health clinics

Associate Medical Director **special projects** included:

- Developed Medication Monitoring System for individual case review and system quantification for state compliance
- Wrote and maintain Community Mental Health Practice Guidelines
- Revised OC Behavioral Health chart including new clinician Intake Assessment and MTPs
- Developing OC Behavioral Health Electronic Health Record
- Established and maintain OC HCA's Continuing Medical Education (CME) accreditation
- Establishing agency's accreditation as a CE provider for MFT's & LCSW's
- Revised Medication consents
- Coordinated Orange County with California's Medi-Cal antipsychotic utilization
- Developed numerous policy & procedures for nurse practitioners and implemented
- Wrote and maintain Behavioral Nurse Practice Guidelines
- Wrote policy & procedures on blood borne pathogens AND maintaining safe hygiene in the clinics
- Establishing agency's accreditation as a CME provider and a CE provider for MFT's & LCSW's
- Training on dual diagnosis treatment guidelines for county / contract / drug & alcohol psychiatrists
- Participated Medi-Cal implementation of outpatient consolidation and ongoing managed care
- Perform outcome studies for community mental health outpatient programs
- Implemented and maintain University of California, Irvine residency training in outpatient clinics
- Implement clinical team meetings in the outpatient clinics
- Liaison with primary care providers, pharmacies and BH clinic staff

## *CME and Topical PRESENTATIONS (2005 – 2014)*

1. Sharps, D. *Reckoning with Dionysus: Dual Diagnosis.* Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/10/05
2. Sharps, D. *Disability: Role of the Private Psychiatrist*. OCPS CME Program. Orange, Ca 12/8/05
3. Sharps, D. Substance Abuse in Primary Care: *Reckoning with Dionysus*. 1st Annual OCPS CME Psychiatrist & PCP Program. Orange, Ca 3/18/06
4. Sharps, D. *Disability: Role of Entitlements, Recovery.* Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/16/06
5. Sharps, D. *Is there a Psychiatric Physician Assistant in your Community Mental Health Clinic (CMHC)? Shouldn't there be?* California Psychiatric Association Annual CME Meeting. Dana Point, Ca 10/8/06
6. Sharps, D. *Disability in Major Psychiatric Disorders: Role of Entitlements and the Treatment Team.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 3/7/07
7. Sharps, D. *When Bacchus has a problem in YOUR office: A TIP from SAMHSA.* 2nd Annual OCPS CME Psychiatrist & PCP Program. Orange, Ca 6/2/07
8. Sharps, D. *Hepatic Impairment in Community Mental Health.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 2/4/08
9. Sharps, D. *Tweaking: California's Methamphetamine & Ecstasy Problem.* 3rd Annual OCPS CME Psychiatrist & PCP Program. Orange, Ca 6/13/08
10. Sharps, D. *Renal Impairment in Community Mental Health.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 8/6/08
11. Sharps, D. *Methamphetamine – Detection & Treatment in Community Mental Health.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 10/1/08
12. Sharps, D. *Methamphetamine – California's Public Health Problem.* Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/13/09
13. Sharps, D. *Antidepressants & Antipsychotics - The Name Doesn't Mean Much Anymore - – a review of FDA indications and off label use of antidepressants & antipsychotics*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 6/3/09
14. Sharps, D. *Antidepressants: Not just for Depression – a review of FDA indications and off label use of antidepressants*. 4th Annual OCPS CME Psychiatrist & PCP Program. Orange, Ca 6/13/09
15. Sharps, D. *Generically Speaking – Generic Medication's Many Relevancies for Community Mental Health*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 12/2/09
16. Sharps, D. '*Abusin' or 'Usin' – Self-medicating or Making Things Worse? Substance Abuse Treatment Goals in a MH Setting*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 2/3/10
17. Sharps, D. *Medications in Bipolar Disorders –Research Efficacy versus Community Mental Health Effectiveness*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 4/14/10
18. Sharps, D. *Preventing and Managing Stress – Avoiding the Paradox of, 'I can do it, I just know I could,,, if I just had the time'.* OCMA Wellness Program for OCMA Physicians. Costa Mesa, Ca 2/24/10



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19. Sharps, D. *Generically Speaking – Generic Medication's Many Relevancies for Community Mental Health*. Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/11/10
20. Sharps, D. *'Abusin' or 'Usin' – Self-medicating or Making Things Worse? Substance Abuse Treatment Goals in a MH Setting*. Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/11/10
21. Sharps, D. *Psychiatric Medications: Relevance for Law Enforcement.* Crisis Intervention Training for Law Enforcement - Understanding Mental Illness on the Street: Ongoing Program for OC Sheriffs, Probation, and Police Departments Developed in cooperation with the County and Golden West College. Anaheim Ca 2008 - 2010
22. Sharps, D. *Preventing and Managing Stress Recognizing and Dealing with Feeling Stressed in Your Practice and in Your Life*. OCMA Wellness Program for OCMA Physicians. Newport Beach, Ca 10/21/10
23. Sharps, D. *Methadone/Buprenorphine Maintenance: Appropriate Clinical Use, Pharmacology, Benefits & Risks.* California Association of Toxicologist. Anaheim, Ca 11/06/10
24. Sharps, D. *To Sleep, Perchance to Dream: Sleep Hygiene for Patients & Clients in a Community Mental Health Setting*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 12/1/10
25. Sharps, D. *Recognizing & Dealing with Feeling Stressed in Your Practice and in Your Life*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 2/11/11
26. Sharps, D. *Treating Psychosis – Early & Comprehensively? Says Who?* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 4/6/11
27. Sharps, D. *Medical Marijuana: Compassionate Use or Feeling too Good?* Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/10/11
28. Sharps, D. *Medical Marijuana: Relevance for Community Psychiatrists in a Community Mental Health Setting*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 6/1/11
29. Sharps, D. *Culture-Bound Syndromes: Relevance for Community Psychiatrists in a Community Mental Health Setting*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 8/10/11

*33.* Sharps, D. *Disability in Psychiatric Disorders: The Role of Entitlements, Recovery, and Community Mental Health*. San Joaquin County CME & CE Presentation for County of San Joaquin Medical Staff and Mental Health Staff. San Joaquin General Hospital and San Joaquin Behavioral Health, San Joaquin, Ca 9/8/11

*34.* Sharps, D. *Nothing I Do Seems to Help: Why is this Patient so Difficult? - Making the Most of Very Difficult Patient Encounters*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 12/7/11

35. Sharps, D. *Nothing I Do Seems to Help: Why is this Patient so Difficult? - Making the Most of Very Difficult Patient Encounters*. CalOptima Health Networks Special Meeting, Orange, Ca 12/15/11

*36.* Sharps, D. *Controlled Substance Prescriptions - Your Data & How to Use the CURES Program in Clinical Practice.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 2/8/12

37. Sharps, D. *Antidepressants & Antipsychotics: What's New, What's the Same, & How to Know it's Working, not Hurting!* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 4/11/12

38. Sharps, D. "*Recovery? But I'm Still Sick" - Managing Medical & Psychiatric Co-occurring Disorders in CMH.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 8/8/12

39. Sharps, D. *Orange County's 1st Spirituality Integration Conference Spirituality in Behavioral Health*. Opening remarks and two workshops with case presentations / discussion for 270 attendees. Santa Ana, Ca 10/4/12

40. Sharps, D. "*There's Nothing Wrong with Me" versus Factitious Symptoms: Managing the Continuum of Denial to Malingering in CMH.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 10/10/12

41. Sharps, D. *CPT Coding & Medical necessity*. OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 12/12/12

42. Sharps, D. *Understanding Upcoming Changes to DSM 5.0.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 02/13/13

43. Sharps, D. *Affordable Care Act, Integrated Care, and Pain Management.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 04/10/13

44. Sharps, D. *Pain Management: Plain Sense Discussions between Doctor and Patient.* Mental Health Association's Annual Meeting of the Minds. Anaheim, Ca 5/15/13

45. Sharps, D. *Medical Conditions that Mimic Impairment.* California District Attorneys Association Program on Drug-Impaired Driver Training for Law Enforcement and Prosecutors. Anaheim, Ca 06/10/13

46. Sharps, D. *CMH Psychiatrist's Response to Managing Symptoms of Anxiety, Insomnia, Inattention, & Pain.* OCBHS CME Rounds for OC BHS Psychiatrists. Orange, Ca 10/11/13

47. Sharps, D. *Alcohol Misuse in Your Practice: What You Can And Should Do When Bacchus Shows Up.* CalOptima CME Workshop for Physicians and Licensed Health Care Professionals. Orange, Ca 02/27/14



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# RESOLUTION NO. 21-0506-03

# RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY

**d.b.a. CalOptima**

## AUTHORIZING THE HIRING OF A CALPERS RETIRED ANNUITANT IN ACCORDANCE WITH GOVERNMENT CODE SECTION 21221(h) AND CERTIFYING THE NATURE OF THE EMPLOYMENT OF DR. RICHARD HELMER

**WHEREAS,** Government (Gov.) Code section 21221(h) of the Public Employees' Retirement Law permits the governing body to appoint a CalPERS retiree to a vacant position requiring specialized skills during recruitment for a permanent appointment, and provides that such appointment will not subject the retired person to reinstatement from retirement or loss of benefits so long as it is a single appointment that does not exceed 960 hours in a fiscal year; and

**WHEREAS**, the CalOptima Board of Directors desires to appoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Medical Director, PACE, Quality & Population Health for CalOptima under Gov. Code section 21221(h), effective May 23, 2021; and

**WHEREAS**, the CalOptima Board of Directors, CalOptima and Dr. Richard Helmer certify that Richard Helmer has not and will not receive a Golden Handshake or any other retirement-related incentive; and

**WHEREAS**, an appointment under Gov. Code section 21221(h) requires the retiree to be appointed into the interim appointment during recruitment for a permanent appointment; and

**WHEREAS**, the governing body has authorized the search for a permanent appointment on May 6, 2021; and

**WHEREAS**, this Gov. Code section 21221(h) appointment shall only be made once and therefore will end on or before June 30, 2022; and

**WHEREAS**, the entire employment appointment document between Dr. Helmer and CalOptima has been reviewed by this body and is attached herein; and

**WHEREAS**, the compensation paid to retirees cannot be less than the minimum nor exceed the maximum monthly base salary paid to other employees performing comparable duties, divided by 173.333 to equal the hourly rate; and

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**WHEREAS**, the maximum monthly base salary for this position is $27,600 and the hourly equivalent is $159.23, and the monthly minimum base salary for this position is $18,450, and the hourly equivalent is $106.44; and

**WHEREAS**, the hourly rate paid to Dr. Helmer will be $159.23; and

**WHEREAS**, Dr. Helmer has not and will not receive any other benefit, incentive, compensation in lieu of benefit or other form of compensation in addition to this hourly pay rate; and

**THEREFORE, BE IT RESOLVED THAT** the CalOptima Board of Director hereby certifies the nature of the employment of Dr. Richard Helmer as described herein and detailed in the attached employment appointment document and that this appointment is necessary to fill the critically needed position of Medical Director, PACE, Quality and Population Health (PACE Medical Director) for CalOptima by May 23, 2021 because the work performed by the PACE Medical Director is critical to the successful operation of PACE and must continue while CalOptima recruits to fill the vacancy. This PACE Medical Director provides clinical leadership and participates in the development and implementation of the PACE program, including policies and procedures for clinical services and the quality assurance program initiatives (QAPI), oversees the clinical care provided by the CalOptima PACE program and ensures quality clinical service delivery to PACE participants, and provides oversight of the physicians, nurse practitioners, pharmacists, and other staff. Having previously served in the role of Chief Medical Officer, Dr. Helmer has insight and knowledge regarding CalOptima's PACE operations, and is qualified to fill the gap during the recruitment process.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this May 6, 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

Attest:

/s/_________________________________________
Sharon Dwiers, Clerk of the Board

May __, 2021

Richard Helmer M.D.

Dear Richard,

It is my pleasure to confirm to you an offer of temporary employment as an As-Needed, Medical Director – Retired Annuitant, to become effective on May 23, 2021 to end on or before June 30, 2022, or a maximum of 960 hours worked within each fiscal year, or upon the commencement of work by a permanent employee hired into the position, whichever comes first.

You will receive an hourly rate of $159.23 payable according to CalOptima's usual payroll schedule, with appropriate deductions withheld as required under federal, state, and local tax laws. You will also receive reimbursement for pre-approved/reasonable costs and expenses incurred while performing your obligations as a Medical Director in accordance with reimbursement policies established by the CalOptima Board of Directors. As a retired annuitant, you are not eligible to receive employee benefits or holiday pay, and you will not accrue paid time off applicable to permanent employees. In accordance with CalPERS' requirements, a retiree may work up to no more than a total of 960 hours within a fiscal year without reinstatement. It is your responsibility to keep track of the total time worked. As a retiree, you must be enrolled as a retired annuitant and payrate with hours worked reported in the "my|CalPERS" system. No retirement contributions are reported by the employer or member for retired annuitants.

All employment at CalOptima is at-will, which means that either the employee or CalOptima may end the employment relationship at any time, with or without cause. By signing this offer letter, you agree and understand that your employment relationship with CalOptima is at-will with no guarantee of employment for any specified term. By signing this offer letter, you agree that this is the final and full agreement regarding the at-will nature of your employment relationship and cannot be later altered unless the Chief Executive Officer of CalOptima and you sign an agreement to the contrary.

Please be advised that you will be a Designated Employee pursuant to CalOptima's Conflict of Interest Code and therefore subject to its provisions, including the annual filing of California Fair Political Practices Commission Form 700: Statement of Economic Interests. Furthermore, because of the sensitive nature of your job responsibilities with CalOptima, your subsequent employment with an entity contracted to provide services to CalOptima creates a potential conflict of interest. You must therefore agree to notify promptly and in writing the CalOptima CEO and the Chair of the Board of Directors if, up to twelve (12) months after terminating employment with CalOptima,

you obtain employment with a CalOptima contractor. You must also agree that, during the twelve months after terminating employment with CalOptima, you will not be directly or indirectly

involved in negotiating, servicing, or soliciting contracts with CalOptima for a contractor by whom you have been employed, or otherwise retained. For one (1) year following separation, you must agree not to actively recruit, solicit, or offer employment to any current CalOptima employee.

I know that with your extensive knowledge and experience you will bring critical expertise and important perspective that will be of great value to us in this vital position to provide continuity in service during this statewide emergency. I believe that you will find this role rewarding as you assist CalOptima in its important mission to deliver quality, accessible, and efficient health care services to its members. We look forward to a positive and productive working relationship. As verification that you accept this offer, please sign the enclosed copy of this letter and return it to me by [**DATE**].

Sincerely,

Richard Sanchez
Chief Executive Officer

**UNEMPLOYMENT CERTIFICATION**

By signing below, I hereby certify that I have not received any unemployment insurance payments within the 12 months prior to this appointment, and I have not provided previous retired annuitant work with any other CalPERS employer

Date: ____________________ Accepted: ____________________________
Richard Helmer

Name (Print): ________________________

**ACKNOWLEDGMENT AND ACCEPTANCE**

By signing below, I hereby accept the offer as described in this letter dated [**DATE**] and understand that it is a conditional offer, which can be revoked. I understand that the position is an As-Needed retired annuitant position with no expectation of continuous employment. I understand that it is my responsibility to ensure that my work hours will not exceed 960 hours per fiscal year, and I understand that any violation of the work hours limitation or CalPERS requirements on my part may impact my current retirement with CalPERS.

Date: ____________________

Accepted: ___________________________
Richard Helmer

Name (Print): ________________________

# Medical Director (PACE, Quality & Population Health)

**Department:** Medical Management
**Reports to:** Chief Medical Officer and Program Director, PACE
**FLSA status:** Exempt
**EEOC Classification:** Officials and Managers: First/Mid-Level
*Revised: 03/29/2021*

## Job Summary

The PACE Medical Director is responsible for the management and oversight of the physicians, nurse practitioners, pharmacists, and other staff assigned to his/her team. The PACE Medical Director oversees the clinical care provided by the CalOptima PACE program and ensures quality clinical service delivery to PACE participants. The PACE Medical Director is also responsible for overseeing clinical service contracts for the PACE program.

## Position Responsibilities

- Provides clinical leadership to the PACE program and participates in the development and implementation of the PACE program, including policies and procedures for clinical services and the quality assurance program initiatives (QAPI).
- Supervises clinical PACE staff, including physicians, physician extenders, and other members of the clinical team assigned to his/her supervision.
- Works jointly with the PACE Program Director to develop, implement, and update policies and procedures for the medical care of PACE participants.
- If needed, provides direct primary clinical care, including oversight of inpatient management and assessments and call coverage rotated with other physicians working in PACE.
- Serves as a liaison between the program and the physician/provider community, including participation in regional or national geriatric societies.
- Reviews all appeals and grievances.
- Coordinates quality assurance activities including the development, implementation, and ongoing evaluation of a quality assurance plan for the program.
- Provides information and conducts presentations regarding the PACE program as required.
- Participates in the Quality Assurance Committee, Ethics Committee, and other work groups, as assigned.
- Other projects and duties as assigned.

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## Knowledge & Abilities:

- Effectively interact with a wide range of health care and social services staff, working together as an interdisciplinary team.
- Work with the PACE Program Director in evaluating staffing needs as census changes.
- Evaluate and assist in establishing contracts for a wide range of clinical services, including hospital, pharmacy, specialists and nursing homes.
- Oversee the utilization of inpatient, pharmaceutical, specialty, and institutional long-term care services.
- Geriatric medicine; special needs of complex geriatric patients.
- Knowledge of industry and professional standards of health care, utilization management, quality improvement and other medical management functions.
- Knowledge of culture and needs of the socially and ethnically diverse population CalOptima serves.
- Knowledge of principles and practices of medical administration.
- Communicate clearly and concisely, both verbally and in writing.
- Utilize computer and appropriate software (e.g. Microsoft Office: Word, Outlook, Excel, PowerPoint) and job specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

## Experience & Education:

- Valid MD license, in good standing, to practice medicine in the State of California required.
- Graduate of an accredited School of Medicine required.
- Minimum five years supervisory and administrative experience required.
- Minimum five years clinical experience required.
- Minimum three years experience working with elderly population required.

## Preferred Qualifications:

- Board certified Geriatrician strongly preferred.

## Physical Demands and Work Environment:

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to talk and hear, particularly for regular communication on the phone.

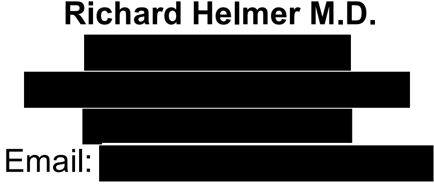
- *Work Environment:* Employee must be able to work effectively within an interdisciplinary team model, interfacing and collaborating with a wide range of clinical and social services disciplines who work together to manage the PACE members' care. The work setting is in an

Adult Day Health Center and primary care clinic environment with moderate noise levels and controlled office temperatures.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

**Richard Helmer M.D.**



Email:

## EDUCATION

**Bachelor of Arts in Environmental Biology**
**University of California**
Santa Barbara, California
MAGNA CUM LAUDE, PHI BETA KAPPA

**Doctor of Medicine**
**Medical College of Wisconsin**
Milwaukee, Wisconsin

## POST DOCTORAL TRAINING

**Residency in Family Medicine**
**University of Miami / Jackson Memorial Hospital**
Miami, Florida

**University of California Irvine / FHP**
**Medical Management Fellowship**
**University of California**
Irvine, California

## BOARD CERTIFICATION AND LICENSURE

**National Board of Medical Examiners**
**Diplomate**

**American Board of Family Medicine**
**Diplomate**

**California Licensure**

**Washington State Licensure**

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## PROFESSIONAL MEMBERSHIP

**American Association of Physician Leadership**
FORUM ON ENTREPRENEURSHIP

**National Committee for Quality Assurance**
SURVEYOR AND REVIEW OVERSIGHT COMMITTEE MEMBER

## PROFESSIONAL EXPERIENCE

**Richard Helmer, MD, Medical Management Consultant** *November, 2018 to Present*
Laguna Beach, California

PRINCIPAL. Focus on medical management, organizational development and strategic initiatives for healthcare organizations.

**CalOptima** *May, 2013 to September, 2018*
Orange, California

CHIEF MEDICAL OFFICER. Returned to Orange County as part of a team to rebuild the executive management team and Medical Affairs Division of a County Organized Health System. Significant achievements have included:

- Reorganization of Medical Affairs and recruitment of almost all of the management staff
- Added capacity and programs to meet the needs of over 200,000 new Medi-Cal members
- Implemented new mental health benefit and brought management of the Medi-Cal line of business in-house
- Led complete revision of Model of Care in response to CMS sanctioning of OneCare D-SNP
- Assumed responsibility for the Program of the All Inclusive Care for the Elderly (PACE) bringing it to profitability and expanding coverage county-wide through the alternative care model
- Formed Enterprise Analytics Department creating an organization-wide approach to data management
- Responsible for the quality improvement program that has resulted in CalOtima being recognizes by National Committee for Quality Assurance (NCQA) Cal Optima's as the top-rated Medicaid plan in overall quality for five years in a row

**Central California Alliance for Health** *August, 2007 to March, 2013*

Scotts Valley, California

CHIEF MEDICAL OFFICER. Began working with the Alliance in a consulting capacity in November, 2006 to evaluate the potential development of a Medicare Advantage Special Needs Program. Subsequently expanded the scope of consultation to include utilization and medical management. During the engagement, was asked to assume the Medical Director position. Projects and program implementation have included: development of data analysis platform, a complete utilization management re-design including implementation of web-based system for concurrent review, prior authorization, case management and grievance and appeals; regulatory submission and organizational readiness for a geographical and product expansions that included over 100,000 lives.

**Pacific Healthcare Group, Inc.** *December, 1994 to November, 2000 and July, 2005 to August, 2007*

Laguna Beach, California

PRESIDENT -

INDEPENDENT CONSULTANT AND INTERIM MEDICAL MANAGEMENT- Clients have included:

- CalOPTIMA
- Mercy Health Plan of Michigan
- Blue Cross / Blue Shield of Tennessee
- Health Insurance Plan (HIP) of Florida
- Trigon Blue Cross/Blue Shield of Virginia
- Fallon Community Health Plan
- United HealthCare of California
- Blue Cross / Blue Shield of Rhode Island
- Blue Cross / Blue Shield of Louisiana
- National HealthPlan, Modesto CA
- Molina Healthcare, Long Beach CA
- Partnership Health Plan
- Rx America
- Fidelis Senior Care
- Physician Web Link / Monarch Heath Care
- Central Coast Alliance for Health

**Molina Healthcare, Inc.**
Long Beach, California

*November, 2000 to July, 2005*

CORPORATE VICE PRESIDENT AND CHIEF MEDICAL OFFICER. After an initial consulting and interim medical management engagement, assumed a full-time position with the company. Had full line responsibly for all medical management and member service functions while preparing the California operations for NCQA accreditation. This was the first, for-profit, Medi-Cal health plan to do so.

As part of the senior management team, participated in the July, 2003 initial public offering. Responsible for medical management leadership for six-state operations with over 850,000 lives. Coordinated medical management aspects of implementation of a Medicare Advantage Special Needs Plan and Prescription Drug Plan.

**TakeCare, Incorporated**

*July, 1992 to November, 1994*

Orange, California

MEDICAL DIRECTOR, SOUTHERN CALIFORNIA. As the first Medical Director for Southern California, integrated the acquired Lincoln National Medical management resources into a single TakeCare program. This included both HMO and PPO products. Network size was approximately 180,000 lives. Participated in the development and implementation of the TakeCare for Seniors product. Chaired the company-wide (approximately 600,000 lives) Pharmacy and Therapeutics Committee and Medical Management transition team for new information system.

**FHP, Incorporated:**

*July, 1990 to June, 1992*

Riverside, California

ASSOCIATE VICE-PRESIDENT MEDICAL AFFAIRS, INLAND REGION. Chief Medical Officer for new region created by the reorganization of California. Members received care through staff model sites, FHP managed IPAs and networks of group practices. Division included seven Medical Directors as well as Utilization and Quality Management departments. Implemented (including obtaining licensure) in-house home health and Hospice programs. Restructured the staff model to a "Group Model" that became the model for FHP spin-off company. Implemented significant claims processing and contractual operational changes including expanded medical review and accrual mechanism. Prepared region for NCQA accreditation.

*July, 1989 to June, 1990*

Salt Lake City, Utah

MEDICAL DIRECTOR, UTAH REGION. Responsible for the Medical Affairs Division which included three Associate Medical Directors, over 120 providers and the

Utilization Review, Risk Management, Quality Assurance and Home Health departments. Participated in the design and development of the Region's' hospital and Medicare risk program. Proposed FHP's first Family Practice Residency program and recruited the program's Director and initial faculty members. This program enrolled its first resident in 1993.

*December, 1988 to June, 1989*

Long Beach, California

ASSOCIATE MEDICAL DIRECTOR. Responsible for the California Staff Model Quality Assurance program and hospital utilization process.

**JMH Health Plan and University of Miami Department of Family Medicine**

Miami, Florida

MEDICAL DIRECTOR OF JMH HEALTH PLAN. ASSISTANT PROFESSOR AND RESIDENCY DIRECTOR, DEPARTMENT OF FAMILY MEDICINE. Participated in all aspects of the development and implementation of the JMH Health Plan, a university medical center-based health maintenance organization. This program was funded with a grant from the Robert Wood Johnson Foundation. The Plan used various clinical sites including a Family Practice Residency training center, community clinics and a university faculty practice. Teaching duties included managed care seminars as well as outpatient and inpatient supervision of residents.

**Private Practice of Family Medicine**
**and Jensen Beach Emergicentre**

Jensen Beach, Florida

DEVELOPER, OWNER AND MEDICAL DIRECTOR OF THE EMERGICENTRE. Developed the first free-standing Urgent Care center, The Jensen Beach Emergicentre, in Martin County, Florida. This was purchased by Columbia Health Care in 1994.

**GOVERNMENT CODE - GOV**

**TITLE 1. GENERAL [100 - 7914]** *( Title 1 enacted by Stats. 1943, Ch. 134. )*

**DIVISION 7. MISCELLANEOUS [6000 - 7599.2]** *( Division 7 enacted by Stats. 1943, Ch. 134. )*

**CHAPTER 21. Public Pension and Retirement Plans [7500 - 7522.74]** *( Heading of Chapter 21 renumbered from Chapter 19 (as added by Stats. 1974, Ch. 1478) by Stats. 1977, Ch. 579. )*

**ARTICLE 4. California Public Employees' Pension Reform Act of 2013 [7522 - 7522.74]** *( Article 4 added by Stats. 2012, Ch. 296, Sec. 15. )*

**7522.56.** (a) This section shall apply to any person who is receiving a pension benefit from a public retirement system and shall supersede any other provision in conflict with this section.

(b) A retired person shall not serve, be employed by, or be employed through a contract directly by, a public employer in the same public retirement system from which the retiree receives the benefit without reinstatement from retirement, except as permitted by this section.

(c) A person who retires from a public employer may serve without reinstatement from retirement or loss or interruption of benefits provided by the retirement system upon appointment by the appointing power of a public employer either during an emergency to prevent stoppage of public business or because the retired person has skills needed to perform work of limited duration.

(d) Appointments of the person authorized under this section shall not exceed a total for all employers in that public retirement system of 960 hours or other equivalent limit, in a calendar or fiscal year, depending on the administrator of the system. The rate of pay for the employment shall not be less than the minimum, nor exceed the maximum, paid by the employer to other employees performing comparable duties, divided by 173.333 to equal an hourly rate. A retired person whose employment without reinstatement is authorized by this section shall acquire no service credit or retirement rights under this section with respect to the employment unless he or she reinstates from retirement.

(e) (1) Notwithstanding subdivision (c), any retired person shall not be eligible to serve or be employed by a public employer if, during the 12-month period prior to an appointment described in this section, the retired person received any unemployment insurance compensation arising out of prior employment subject to this section with a public employer. A retiree shall certify in writing to the employer upon accepting an offer of employment that he or she is in compliance with this requirement.

(2) A retired person who accepts an appointment after receiving unemployment insurance compensation as described in this subdivision shall terminate that employment on the last day of the current pay period and shall not be eligible for reappointment subject to this section for a period of 12 months following the last day of employment.

(f) A retired person shall not be eligible to be employed pursuant to this section for a period of 180 days following the date of retirement unless he or she meets one of the following conditions:

(1) The employer certifies the nature of the employment and that the appointment is necessary to fill a critically needed position before 180 days have passed and the appointment has been approved by the governing body of the employer in a public meeting. The appointment may not be placed on a consent calendar.

(2) (A) Except as otherwise provided in this paragraph, for state employees, the state employer certifies the nature of the employment and that the appointment is necessary to fill a critically needed state employment position before 180 days have passed and the appointment has been approved by the Department of Human Resources. The department may establish a process to delegate appointing authority to individual state agencies, but shall

audit the process to determine if abuses of the system occur. If necessary, the department may assume an agency's appointing authority for retired workers and may charge the department an appropriate amount for administering that authority.

(B) For legislative employees, the Senate Committee on Rules or the Assembly Rules Committee certifies the nature of the employment and that the appointment is necessary to fill a critically needed position before 180 days have passed and approves the appointment in a public meeting. The appointment may not be placed on a consent calendar.

(C) For employees of the California State University, the Trustees of the California State University certifies the nature of the employment and that the appointment is necessary to fill a critically needed position before 180 days have passed and approves the appointment in a public meeting. The appointment may not be placed on a consent calendar.

(3) The retiree is eligible to participate in the Faculty Early Retirement Program pursuant to a collective bargaining agreement with the California State University that existed prior to January 1, 2013, or has been included in subsequent agreements.

(4) The retiree is a public safety officer or firefighter hired to perform a function or functions regularly performed by a public safety officer or firefighter.

(g) A retired person who accepted a retirement incentive upon retirement shall not be eligible to be employed pursuant to this section for a period of 180 days following the date of retirement and subdivision (f) shall not apply.

(h) This section shall not apply to a person who is retired from the State Teachers' Retirement System, and who is subject to Section 24214, 24214.5, or 26812 of the Education Code.

(i) This section shall not apply to (1) a subordinate judicial officer whose position, upon retirement, is converted to a judgeship pursuant to Section 69615, and he or she returns to work in the converted position, and the employer is a trial court, or (2) a retiree of the Judges' Retirement System or the Judges' Retirement System II who is assigned to serve in a court pursuant to Section 68543.5.

*(Amended by Stats. 2014, Ch. 238, Sec. 1. (AB 2476) Effective January 1, 2015.)*

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**GOVERNMENT CODE - GOV**

**TITLE 2. GOVERNMENT OF THE STATE OF CALIFORNIA [8000 - 22980]** *( Title 2 enacted by Stats. 1943, Ch. 134. )*

**DIVISION 5. PERSONNEL [18000 - 22980]** *( Division 5 added by Stats. 1945, Ch. 123. )*

**PART 3. PUBLIC EMPLOYEES' RETIREMENT SYSTEM [20000 - 21716]** *( Part 3 repealed and added by Stats. 1995, Ch. 379, Sec. 2. )*

**CHAPTER 12. Retirement from Employment [21060 - 21233]** *( Chapter 12 added by Stats. 1995, Ch. 379, Sec. 2. )*

**ARTICLE 8. Employment after Retirement [21220 - 21233]** *( Article 8 added by Stats. 1995, Ch. 379, Sec. 2. )*

**21221.** A retired person may serve without reinstatement from retirement or loss or interruption of benefits provided by this system, as follows:

(a) As a member of any board, commission, or advisory committee, upon appointment by the Governor, the Speaker of the Assembly, the President pro Tempore of the Senate, director of a state department, or the governing board of the contracting agency. However, the appointment shall not be deemed employment within the meaning of Division 4 (commencing with Section 3200) and Division 4.5 (commencing with Section 6100) of the Labor Code, and shall not provide a basis for the payment of workers' compensation to a retired state employee or to his or her dependents.

(b) As a school crossing guard.

(c) As a juror or election officer.

(d) As an elective officer on and after September 15, 1961. However, all rights and immunities which may have accrued under Section 21229 as it read prior to that section's repeal during the 1969 Regular Session of the Legislature are hereby preserved.

(e) As an appointive member of the governing body of a contracting agency. However, the compensation for that office shall not exceed one hundred dollars ($100) per month.

(f) Upon appointment by the Legislature, or either house, or a legislative committee to a position deemed by the appointing power to be temporary in nature.

(g) Upon employment by a contracting agency to a position found by the governing body, by resolution, to be available because of a leave of absence granted to a person on payroll status for a period not to exceed one year and found by the governing body to require specialized skills. The temporary employment shall be terminated at the end of the leave of absence. Appointments under this section shall be reported to the board and shall be accompanied by the resolution adopted by the governing body.

(h) Upon interim appointment by the governing body of a contracting agency to a vacant position during recruitment for a permanent appointment and deemed by the governing body to require specialized skills or during an emergency to prevent stoppage of public business. A retired person shall only be appointed once to this vacant position. These appointments, including any made concurrently pursuant to Section 21224 or 21229, shall not exceed a combined total of 960 hours for all employers each fiscal year. The compensation for the interim appointment shall not exceed the maximum monthly base salary paid to other employees performing comparable duties as listed on a publicly available pay schedule for the vacant position divided by 173.333 to equal an hourly rate. A retired person appointed to a vacant position pursuant to this subdivision shall not receive any benefits, incentives, compensation in lieu of benefits, or any other forms of compensation in addition to the hourly rate. A

retired annuitant appointed pursuant to this subdivision shall not work more than 960 hours each fiscal year regardless of whether he or she works for one or more employers.

(i) Upon appointment by the Administrative Director of the Courts to the position of Court Security Coordinator, a position deemed temporary in nature and requiring the specialized skills and experience of a retired professional peace officer.

*(Amended by Stats. 2012, Ch. 833, Sec. 8. (SB 987) Effective January 1, 2013.)*

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To 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 |
| | 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 |

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| | Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|---|
| | 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 |
| | Deputy Clerk of the Board | K | 684 | $70,000 | $84,000 | $98,000 |
| * | Director Audit & Oversight | R | 546 | $144,000 | $174,000 | $204,000 |

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| | Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|---|
| * | 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 |
| ** | 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 |

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|
| 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 |
| 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 |

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|
| 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 |
| 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 |

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# CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| | Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|---|
| | 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 |
| | 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 |

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## CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
## Effective as of May 01, 2014

| | Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|---|
| | 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 |
| | 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 |

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## CalOptima - Annual Base Salary Schedule - Revised March 04, 2021
## To be Implemented March 14, 2021
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| Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|
| 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 |
| 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 |

| Job Title | Pay Grade | Job Code | Min | Mid | Max |
|---|---|---|---|---|---|

* 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.

Better. Together.



# Medical Director (Behavioral Health)

## Posting Date

2/18/2021

## Tracking Code

13021-021821

**Department(s):** Medical Management
**Reports to:** Chief Medical Officer (CMO)
**FLSA status:** Exempt
**Salary Grade:** V - $221,400 - $331,200

The Medical Director for Behavioral Health (BH) is responsible for clinical oversight and management of CalOptima's behavioral health activities including, case management, utilization management, quality management, and contracted services.

**Position Responsibilities:**

- Provides strategic direction for the Behavioral Health Department.
- Provides quality oversight and lead the quality efforts for Behavioral Health.
- Develops and implements medical policies for Behavioral Health.
- Provides direction and control of current medical practices for Behavioral Health ensuring that medical personnel for the plan follow medical protocols and rules of conduct.
- Ensures that medical decisions regarding behavioral health are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Oversees reporting and profiling of behavioral health providers.
- Ensures the appropriate and timely use of criteria and guidelines in the administration of behavioral health treatment.
- Ensures that assigned patients are provided behavioral health services and necessary medical attention at all locations.

- Works with the Contracting department to ensure a full and appropriate primary and specialty behavioral health care provider network for members.
- Consults on written protocol for behavioral health providers to ensure adherence to standards and quality of care. Coordinate professional interactions amongst practitioners and lend assistance toward correcting any deviation from standards. Develop relationships with directly contracted behavioral health providers.
- Participates in the quality management program for behavioral health providers which includes protocol, procedures, oversight, and training in the following areas:
  - Provider selection
  - Credentialing
  - Quality assessment studies
  - Peer review activities
  - Referral management
  - Pre-admission authorization
  - Prospective, concurrent and retrospective review
  - Utilization review reporting and evaluation
  - Case management
  - NCQA accreditation
- Reviews State and Federal mandated benefits to ensure CalOptima Behavioral Health is in full compliance through its providers.
- Ensures the privacy and security of Protected Health Information (PHI) as outlined in CalOptima's policies and procedures relating to HIPAA compliance.
- Any other duties as required to ensure the plan operations are successful.
- Other projects and duties as assigned.

**Knowledge & Abilities:**

- Manage a large point of service network of providers.
- Develop and implement appropriate medical service contracts and monitor compliance.
- Plan, organize, and direct utilization review, quality management, case management, health education, and grievance activities.
- Ensure appropriate and cost-effective medical care and services to members not covered by a contracted health plan.
- Establish and maintain effective interpersonal relationships with all levels of staff, other programs, agencies, and the general public.
- Communicate clearly and concisely, both verbally and in writing.
- Utilize computer and appropriate software (e.g., Microsoft Office: Word, Outlook, Excel, PowerPoint) and job specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

**Experience & Education:**

- Current, valid, unrestricted California Physician and Surgeon's License with Board certification in Psychiatry required.
- 5+ years of Medical Administrative experience required.
- Utilization Management experience with expertise in Medi-Cal managed care and Medicare required.

**Preferred Qualifications:**

- Sub-specialization or additional training and experience in substance use disorder with understanding of American Society of Addiction Medicine (ASAM) Levels-of-Care with the County Organized Delivery System Drug Medi-Cal (ODS – DMC) preferred.
- Additional training with children including understanding of County Levels-of-Care, Regional Center, and Applied Behavioral Analysis for Autism Spectrum Disorder (ASD), Intellectual Disabilities and other non-ASD diagnoses preferred.
- Expertise in medical program design preferred.

**Knowledge of:**

- Electronic Health Records (EHR) typically used by Behavioral Health (BH) provider, Medical Providers, Hospitals and Managed Care.
- Administrative practices and procedures including but not limited to quality assessment and improvement, utilization review, peer review, credentialing, and risk management.
- Rules regulations, policies, and standards related to managed care, including California Department of Health Care Services (DHCS), and California Department of Managed Care Services (DHMS)
- Effective supervision and organization.
- Pay for Value reimbursement and other innovative BH provider reimbursement that focuses on quality.
- Medi-Cal services coordination with Local Education Authorities (LEA)
- Methods, techniques, practices, principles, and literature in Psychiatry including psychopharmacology for formulary and non-formulary medications, other psychiatric treatments including innovative / experimental treatments.
- Methods, techniques, practices, principles, and literature in the broad field of medical sciences and an overview of the highly specialized techniques, procedures and equipment used in the medical or surgical specialists.

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# Medical Director (PACE, Quality & Population Health)

## Posting Date

4/6/2021

## Tracking Code

05636-040621

**Department:** Medical Management
**Reports to:** Chief Medical Officer and Program Director, PACE
**FLSA status:** Exempt
**Salary Grade:** V - $221,400 - $331,200

**Job Summary**

The PACE Medical Director is responsible for the management and oversight of the physicians, nurse practitioners, pharmacists, and other staff assigned to his/her team. The PACE Medical Director oversees the clinical care provided by the CalOptima PACE program and ensures quality clinical service delivery to PACE participants. The PACE Medical Director is also responsible for overseeing clinical service contracts for the PACE program.

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## Position Responsibilities:

- Provides clinical leadership to the PACE program and participates in the development and implementation of the PACE program, including policies and procedures for clinical services and the quality assurance program initiatives (QAPI).
- Supervises clinical PACE staff, including physicians, physician extenders, and other members of the clinical team assigned to his/her supervision.
- Works jointly with the PACE Program Director to develop, implement, and update policies and procedures for the medical care of PACE participants.
- If needed, provides direct primary clinical care, including oversight of inpatient management and assessments and call coverage rotated with other physicians working in PACE.
- Serves as a liaison between the program and the physician/provider community, including participation in regional or national geriatric societies.
- Reviews all appeals and grievances.
- Coordinates quality assurance activities including the development, implementation, and ongoing evaluation of a quality assurance plan for the program.
- Provides information and conducts presentations regarding the PACE program as required.
- Participates in the Quality Assurance Committee, Ethics Committee, and other work groups, as assigned.
- Other projects and duties as assigned.

## Knowledge & Abilities:

- Effectively interact with a wide range of health care and social services staff, working together as an interdisciplinary team.
- Work with the PACE Program Director in evaluating staffing needs as census changes.
- Evaluate and assist in establishing contracts for a wide range of clinical services, including hospital, pharmacy, specialists and nursing homes.
- Oversee the utilization of inpatient, pharmaceutical, specialty, and institutional long-term care services.
- Geriatric medicine; special needs of complex geriatric patients.
- Knowledge of industry and professional standards of health care, utilization management, quality improvement and other medical management functions.
- Knowledge of culture and needs of the socially and ethnically diverse population CalOptima serves.
- Knowledge of principles and practices of medical administration.
- Communicate clearly and concisely, both verbally and in writing.
- Utilize computer and appropriate software (e.g. Microsoft Office: Word, Outlook, Excel, PowerPoint) and job specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

## Experience & Education:

- Valid MD license, in good standing, to practice medicine in the State of California required.
- Graduate of an accredited School of Medicine required.
- Minimum five years supervisory and administrative experience required.
- Minimum five years clinical experience required.
- Minimum three years experience working with elderly population required.

## Preferred Qualifications:

- Board certified Geriatrician strongly preferred.

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*Continued to a Future Meeting*

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

14. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

**Contacts**

Ladan Khamseh, Chief Operating Officer (714) 246-8866
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

**Recommended Action**

Approve modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting [Medi-Cal, OneCare, OneCare Connect]

**Background**

CalOptima is obligated to comply with Department of Health Care Services (DHCS) Medi-Cal contractual provisions and All Plan Letter guidance addressing federal Medicaid regulatory requirements for the submission of data and reports. CalOptima is also obligated to comply with the Centers for Medicare & Medicaid Services (CMS) contractual provisions and regulatory guidance addressing Medicare requirements for the submission of data and reports. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting (HH.2003) identifies the Medi-Cal and Medicare data and reporting requirements, providing guidance on the submission and evaluation of more than 80 types of reports that Health Networks and other delegated entities are required to submit to CalOptima.

This Policy, first made effective in 1998, impacts CalOptima's Medi-Cal, OneCare, and OneCare Connect programs. Policy HH.2003 requires that each Health Network or other delegated entity submit these reports to CalOptima, as specified in its contract with CalOptima and the Policy's "Timely and Appropriate Submission Grid." The Policy undergoes routine review and is updated as necessary to ensure that the Policy and its attachments reflect the latest applicable reporting requirements.

**Discussion**

Following the most recent review cycle, staff identified modifications needed to provide additional clarity and consistency in the Policy's overall language and to reflect the most current operational procedures. Current revisions include non-substantive formatting and syntactical updates, revised Health Network applicability indicators for specified reports, updated language for standardization and report naming conventions, and additional reports related to delegated activities.

Staff recommends that the Board approve the modifications to Policy HH.2003: Health Network and Delegated Entity Reporting in order to provide additional clarity and consistency regarding reporting requirements for CalOptima's Health Networks and other delegated entities. The changes will further support Health Networks and other delegated entities in identifying and submitting applicable reports, thereby ensuring compliance with CalOptima requirements.

**Fiscal Impact**

The recommended action to approve revisions to CalOptima Policy HH.2003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

**Rationale for Recommendation**

Updates to Policy HH.2003: Health Network and Delegated Entity Reporting will ensure verbiage is consistent throughout the Policy and reflects the applicability of CalOptima reporting requirements for all Health Networks and other delegated entities.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Final BOD Packet for Policy HH.2003: Health Network and Delegated Entity Reporting, which includes redlined and clean versions of the following documents:
   - HH.2003: Health Network and Delegated Entity Reporting
   - Policy Attachment A: Timely and Appropriate Submission Grid ("Report Grid")
   - Policy Attachment B: Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

*/s/ Richard Sanchez* *04/29/2021*

**Authorized Signature** **Date**

| | |
|---|---|
| Policy: | HH.2003 |
| Title: | **Health Network and Delegated Entity Reporting** |
| Department: | Network Operations |
| Section: | Health Network Relations |

*CEO Approval:*

| | |
|---|---|
| Effective Date: | 10/01/1998 |
| Revised Date: | TBD |

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☐ PACE
☐ Administrative

For 20210506 BOD Review Only

1 **I. PURPOSE**
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3 This policy outlines the process for submission and evaluation of reports that a Health Network or
4 Delegated Entity is required to submit to CalOptima.
5
6 **II. POLICY**
7
8 A. Each Health Network or Delegated Entity shall be responsible for submission of reports to
9 CalOptima, as required by CalOptima or as specified in its contract, the Report Binder (including but
10 not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and
11 procedures.
12
13 B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated
14 Entities in the Report Binder.
15
16 C. The Report Binder shall contain the following:
17
18 1. Report Grid;
19
20 2. Report Grid Supplement;
21
22 3. Report Templates; and
23
24 4. Letter Templates.
25
26 D. Each responsible CalOptima department shall be accountable for:
27
28 1. Identifying required reports;
29
30 a. Reports must list all applicable regulatory, contractual, and policy citations and include all
31 required data elements.
32 2. Creating and maintaining the Table of Authorities for each report;
33 3. Creating templates and all applicable reporting formats, instructions, and technical guidelines;
34

4. Monitoring submission and timeliness of reports;

5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

7. Escalating issues of continued noncompliance to the Office of Compliance.

E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

## III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, on an ongoing basis:

a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

b. With the assistance of the Office of Compliance, review the Report Binder to:

i. Update or correct existing reports;

ii. Identify new reports and associated regulatory, contractual, and policy citations to support new reports;

iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

1. The Health Network Relations Department shall, quarterly, and as necessary:

a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements;

i. CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

For 20210506 BOD Review Only

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments;

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder (including, but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

a. CalOptima's secure FTP site; or

b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder and CalOptima's policies and procedures;

b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

d. Report continued noncompliance to the Office of Compliance.

4. The Health Network Relations Department, upon receipt of notification from the responsible department of unsuccessful attempts to contact the Health Network or Delegated Entity, shall:

a. Contact the Health Network or Delegated Entity to obtain the missing report(s) and, if necessary, escalate the issue to the Health Network's senior management; and

b. Work with the department and Health Network or Delegated Entity to correct any content, formatting, or submission issues, if applicable.

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5. The Office of Compliance, upon receipt of notification from the responsible department of a Health Network or Delegated Entity's continued noncompliance, shall take appropriate action in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

## IV. ATTACHMENT(S)

A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

## V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~G. Standard Reporting Requirements Matrix~~

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency |
|---|---|
| 04/29/2016 | Department of Health Care Services (DHCS) |
| 01/31/2018 | Department of Health Care Services (DHCS) |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 12/03/2020 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 10/01/1998 | HH.2003 | Health Network Reporting | Medi-Cal |
| Revised | 12/01/1999 | HH.2003 | Health Network Reporting | Medi-Cal |
| Revised | 10/01/2002 | HH.2003 | Health Network Reporting | Medi-Cal |
| Revised | 07/01/2004 | HH.2003 | Health Network Reporting | Medi-Cal |
| Revised | 01/01/2007 | HH.2003 | Health Network Reporting | Medi-Cal |
| Revised | 12/01/2015 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 09/01/2016 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |

For 20210506 BOD Review Only

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 12/01/2017 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 11/01/2018 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 05/01/2019 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/03/2020 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | TBD | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |

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1 IX. **GLOSSARY**
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| Term | Definition |
|---|---|
| Corrective Action Plan (CAP) | A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators. |
| Delegated Entity | For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members. |
| Health Network | For purposes of this policy, a Physician-Hospital Consortia (PHC), Physician Medical Group (PMG), or a Shared Risk Group (SRG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Letter Templates | For the purposes of this policy, regulatory letter templates issued by regulatory agencies to be used by Health Networks and Delegated Entities for member communications, as required by applicable contractual, policy, and regulatory requirements. |
| Report Template | A blank form of each report also including instructions and file layout and/or data dictionary. |
| Sanction | Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs. |
| Table of Authorities | For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid. |
| Timely and Appropriate Submission Binder ("Report Binder") | A soft copy document that identifies all reports required of Health Networks to meet CalOptima's operational and regulatory compliance; contains the Report Grid and Report Templates, as well as a data certification statement. |
| Timely and Appropriate Submission Grid ("Report Grid") | A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy. |
| Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement") | A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy. |

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Policy: HH.2003
Title: **Health Network and Delegated Entity Reporting**
Department: Network Operations
Section: Health Network Relations

*CEO Approval:*

Effective Date: 10/01/1998
Revised Date: TBD

Applicable to:
☒ Medi-Cal
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For 20210506 BOD Review Only

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D. Each responsible CalOptima department shall be accountable for:

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| Revised | 12/01/2015 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 09/01/2016 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/01/2017 | HH.2003 | Health Network Reporting | Medi-Cal |

For 20210506 BOD Review Only

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| | | | | OneCare<br>OneCare Connect |
| Revised | 11/01/2018 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 05/01/2019 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/03/2020 | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | TBD | HH.2003 | Health Network Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |

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For 20210506 BOD Review Only

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| Sanction | Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs. |
| Table of Authorities | For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid. |
| Timely and Appropriate Submission Binder ("Report Binder") | A soft copy document that identifies all reports required of Health Networks to meet CalOptima's operational and regulatory compliance; contains the Report Grid and Report Templates, as well as a data certification statement. |
| Timely and Appropriate Submission Grid ("Report Grid") | A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy. |
| Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement") | A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy. |

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For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| Annual Audit | Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Annually; Per process** | 1_AORPT_**HN**_**CAT** | HN = Health network # CAT = Audit Category | hn_reporting | Zip | x | x | x | x | x | x | x | |
| Claims XML Universe | Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0. | /users/Documentation Library/XML Version 2.0/Claims | Audit and Oversight | **Monthly: 2nd of every month** | 2_XMLRPT_**HN**_CLM_**YYYYMM**_**##**.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | x | x | |
| Claims Universe Case Files | Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN**_**MMYYYY**_CLAIMS_**LB**_FILES | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Credentialing Monthly Universe | Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight and Quality Improvement | **Health Networks and Kaiser Monthly: 2nd of every month VSP Quarterly: January 10, April 10, July 10, October 10** | 2_AORPT_QIRPT_**HN**_**MMYYYY**_CRED | MM = 2 digit month | hn_reporting | Excel | x | x | x | x | x | x | x | |
| Credentialing Universe Monthly Case Files | Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN**_**MMYYYY**_CRED_FILES | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect) | Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 2nd of every month** | 1_AORPT_**HN**_**MMYYYY**_NOMNC_**LB** | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect) | hn_reporting | Word | | x | x | x | | | x | |
| NOMNC Files (OneCare & OneCare Connect) | Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN**_**MMYYYY**_NOMNC_FILES_LB | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | | x | x | x | | | x | |
| Provider Dispute Resolution (PDR) XML Universe | Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 2nd of every month** | 1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | x | x | |
| PDR Universe Case Files | Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN**_**MMYYYY**_PDR_**LB**_FILES | HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Provider Directory Universe Case Files | Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Annually, per request** | 1_AORPT_**HN**_PD_**QTYYYY** | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | PDF (zip) | x | x | x | x | | | x | |
| Utilization Management (UM) XML Universe | Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1. | /users/Documentation Library/XML Version 2.1/Authorizations | Audit and Oversight | **Monthly: 2nd of every month** | 2_XMLRPT_**HN**_UM_**YYYYMM**_##.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | | x | |
| UM Universe Case Files | Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN**_**MMYYYY**_**LB**_Files | HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD

| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | Line of Business: MEDI-CAL | ONECARE | ONECARE CONNECT | Report Requirement Indicator: Health Networks (Except Kaiser) | Kaiser | VSP | Report Type: Oversight | Reimbursement |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser | Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/ | Behavioral Health | **Monthly:** **15th of every month** | 1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month | hn_reporting | Excel | x | | | | x | | x | |
| Mental Health Grievances and Appeals (Medi-Cal) - Kaiser | Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report, containing mental health grievances and appeals data. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/ | Behavioral Health | **Quarterly; January 20, April 20, July 20, October 20** | Mental Health Reporting Template.xlsx<br>Send via email to behavioralhealth@caloptima.org | | Secure email | Excel | x | | | | x | | x | |
| Case Management Log | Health Networks shall submit monthly Case Management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly:** **15th of every month** | 1_CMRPT_**HN_MMYYYY**_CM | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | x | x | x | | x | |
| Continuity of Care (Whole-Child Model) | Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Weekly; every Tuesday by 10 am for the prior week's activity** | 1_WCMMC_**HN_YYYYMMDD**_COC | HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year | Managed_HN_Reporting/ WCM/Inbound | Excel | x | | | x | x | | x | |
| Enhanced Monitoring Report (WCM) | Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, Regulatory Affairs | **Quarterly; 5th day after the end of the quarter** | 1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | Managed_HN_Reporting/ WCM/Inbound | Excel | x | | | x | x | | x | |
| Health Homes Program (HHP) Enrollment and Disenrollment Report | Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly:** **10th of every month** | **HN**_HHP_Enrollment.csv | HN = Health network reporting # | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| HHP Finalized Engagement List (FEL) Return File | Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly:** **10th of every month** | **HN**_HHP_ReturnFEL | HN = Health network reporting # | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| HHP Services | Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly:** **10th of every month** | 1_HHPServices_**HN_YYYYMM**.csv | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| Implementation Audit (OneCare Connect) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_OCC_Review_**MMYYYY** | HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Implementation Audit (OneCare) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_OC_Review_**MMYYYY** | HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month | OC/RevisedMOC/Inbound | PDF | | x | | x | | | x | |
| Implementation Audit (Seniors and Persons with Disabilities (SPD)) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_Review_**MMYYYY** | HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month | MediCal/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |
| Organ Transplant - Kaiser | Kaiser shall submit monthly report of members engaged in the organ transplant process. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly:** **15th of every month** | 1_CMRPT_04_**MMYYYY**_OT | MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Annual Redetermination Files | Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_WCM_AR_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | WCM Revised MOC/Inbound | PDF | x | | | x | x | | x | |
| Individual Care Plan/Health Action Plan (ICP/HAP) bundle | Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | HN#_CIN_HHP_MMDDYYYY | HN=Health network reporting #,CIN-, MM=2 digit month, DD-2 digit day, YYYY=4 digit year (MMDDYYY=date ICP/HAP completed) | HN#HNname/MediCal/HHP MOC/Inbound | PDF | x | | | x | x | | x | |
| Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_ICP_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Interdisciplinary Care Team (ICT) Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | SPD/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |

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# Timely and Appropriate Submission Grid - Master

| Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| ICT Bundle (OneCare) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBER CIN**_ICT_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | OneCare/RevisedMOC/Inbound | PDF | | x | | x | | | x | |
| Long Term Care (LTC) ICP Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Pediatric ICT Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | SPD/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |
| Model of Care (MOC) SPD Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly: 6th of every month** | **HN271CCYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | SPD Revised MOC/Inbound | Pipe delimited text file | x | | | x | ~~x~~ **[Remove]** | | x | |
| MOC Tracking Log (OneCare Connect) | Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly: 6th of every month** | **HN871CCYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | OCC/RevisedMOC/Inbound | Pipe delimited text file | | | x | x | | | x | |
| MOC Tracking Log (OneCare) | Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly: 6th of every month** | **HN571CCYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | OneCare/RevisedMOC/Inbound | Pipe delimited text file | | x | | x | | | x | |
| MOC WCM Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly: 6th of every month** | HN275**CCYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | WCM Revised MOC/Inbound | Pipe delimited text file | x | | | x | | | x | |
| Network Staff Legend File | Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly: 6th of every month** | **HN429YYYYMMDD** | HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day | /RevisedMOC/Inbound | Pipe delimited text File | x | x | x | x | | | x | |
| WCM ICP Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 days of HRA completion. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_WCM_ICT_**MMDDYYYY** | HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year | WCM Revised MOC/Inbound | PDF | x | | | x | x | | x | |
| DHCS WCM Report - Kaiser | Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, GARS, Utilization Management | **Monthly: 15th of every month First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter** | 1_WCMMC_04_**YYYYMM**_DHCS | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | | x | | x | |
| Population Health Management (PHM) Program Description - Kaiser | Kaiser shall develop a PHM program description and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management and Population Health Management | **Annually: February 15** | 2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | | x | |
| DHCS WCM Report | Health Networks shall submit monthly report of WCM authorizations and care coordination. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, Utilization Management | **Monthly: 15th of every month First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter** | 1_WCMMC_**HN_YYYYMM**_DHCS | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | x | | | x | |
| Claims Third Party Liability (TPL) (Medi-Cal) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 30th of every month** | 1_CLMRPT_**HN_MMYYYY**_TPL | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel & PDF | x | | | x | x | | x | |
| Claims TPL (OneCare Connect) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 30th of every month** | 1_CLMRPT_**HN_MMYYYY**_TPL_DB | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel & PDF | | | x | x | | | x | |

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# Timely and Appropriate Submission Grid - Master

| Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| DHCS Post-Payment Recovery Report (Medi-Cal Only) | Health Networks shall submit monthly report of post payment recovery data for other health coverage (OHC) claims to CalOptima. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 3rd business day of every month** | 1_MCPPR_XX_YYYYPP_SS | HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year | hn_reporting | Text File | x | | | x | x | | x | |
| Customer Service Call Log Universe | Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: January 7, April 7, July 7, October 7** | MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY** | HN = Health network # QQ = 2 digit quarter (Q1, etc) YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| Health Network Dashboard | Health Networks shall submit report of call center statistics for monthly review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Monthly: 15th of every month** | 2_HMRPT_CSRPT_**HN**_**MMYYYY**_Dashboard | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |
| Interpreter Services Utilization Report | Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: January 30, April 30, July 30, October 30** | 2_CSRPT_QIRPT_**HN**_**QTYYYY**_CCS_2019 | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |
| DHCS NMT/NEMT Report - Kaiser | Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service, GARS | **Monthly: 27th of every month** | 2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY** | MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Annual Audited Financial Statements | Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Annual submission due 120 days after organization's fiscal year ends** | 1_FINRPT_**HN**_Annual**YYYY**_AAFS | HN = Health network reporting # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Incurred But Not Reported (IBNR) Documentation | Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Annual submission due 120 days after organization's fiscal year ends** | 1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements | HN = Health network reporting # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Medical Loss Ratio (MLR) | Health Networks shall submit interim and final reports of the Health Network MLR. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Interim: January - June due August 15.** **Interim: January - December due February 15** **Final: Annual submission of all 12 months due June 30** | 1_FINRPT_**HN**_**SemiAnnualYYYY**_MLR 1_FINRPT_**HN**_**AnnualYYYY**_MLR 1_FINRPT_**HN**_**FinalYYYY**_MLR | HN = Health network reporting # YYYY= 4 digit year | hn_reporting | Excel (using most current AFRF) | x | | x | x | | | x | |
| Risk Bearing Organization (RBO) Report | Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). | /users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance | Finance | **Annual submission due 150 days after the fiscal year ends.** **Quarterly: February 15, May 15, August 15, November 15** | 1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN**_**QTYYYY**_DMHC (Quarterly) | HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter # | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Total Business Reports | Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Quarterly: February 15, May 15, August 15, November 15** | 1_FINRPT_**HN**_**QTYYYY**_TBFS | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| DHCS Quarterly Report - Kaiser | Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: January 23, April 23, July 23, October 23** | 1_GARSRPT_04_**QTYYYY**_DHCS | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Grievances Volume Report Kaiser | Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: January 23, April 23, July 23, October 23** | 1_GARSRPT_HMO04_QQYYYY_VOL | QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Community-Based Adult Services (CBAS) Report - Kaiser | Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS, Customer Service, Long Term Services and Supports | **Quarterly: January 23, April 23, July 23, October 23** | 3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS | QT = 2 digit Quarter # YYYY = 4 digit year | Incoming | Text File | x | | | | x | | x | |
| DHCS Data Certification Statement | Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Monthly: 25th of every month** | 1_AORPT_**HN**_Data Certification_**MMYYYY** | HN = Health network # | hn_reporting | PDF | x | | | x | x | x | x | |
| Health Network Newly Contracted Provider Training Report | Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Quarterly: January 25, April 25, July 25, October 25** | 1_HMRPT_**HN**_**QTYYYY**_NCT | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |

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# Timely and Appropriate Submission Grid - Master

| Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| Primary Care Provider (PCP) Upload File | Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Bi-monthly: 10th and 25th of every month** | **HN**204**JJJ** | HN = Health network reporting # JJJ = Julian Date | hn_reporting | Excel | x | | | x | | | x | |
| DHCS Supplemental Data – Kaiser | Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/IS | IS | **Monthly; 15th of every month** | CalOptima_KSR_PRD_Supplementals_[yyyymm].txt | YYYY= 4 digit year MM = 2 digit month | Incoming | Text File | x | | | | x | | x | |
| Vision Service Plan (VSP) Provider Roster | VSP shall submit monthly report of VSP providers for the print and online provider directories. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS | PDMS | **Monthly: 15th of every month** | VSP_Medicaid_CA_Orange_County_Provider_Listing **_YYYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | | Excel | x | | | | | x | x | |
| Health Education Calendar Kaiser | Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually: January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HECALENDAR | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Health Education Individual Encounters - Kaiser | Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HEIE | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Word | x | | | | x | | x | |
| Health Education Other Encounters - Kaiser | Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HEOE | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Word | x | | | | x | | x | |
| Perinatal Support Services (PSS) Encounters - Kaiser | Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Monthly: 15th of every month** | 1_DMRPT_04_**MMYYYY**_PSS_Services | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Access and Availability Report - Kaiser | Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Analytics | Quality Analytics | **Annually: February 15** | 1_MDMRPT_04_Annual**YYYY**_Access | YYYY = 4 digit year | hn_reporting | Excel or Word or PDF | x | | | | x | | x | |
| Quality Improvement (QI) Evaluation (Previous Year) - Kaiser, VSP | Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15** | 1_QIRPT_**HN**_Annual**YYYY**_QIE | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | x | x | |
| QI Program - Kaiser, VSP | Kaiser shall develop an annual QI report and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15** | 1_QIRPT_**HN**_Annual**YYYY**_QIP | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | x | x | |
| QI Work Plan - Kaiser, VSP | Kaiser shall report progress towards QI program goals semi-annually. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Semi-Annually: February 15 and August 15** | 1_QIRPT_**HN**_SemiAnnual**YYYY**_QI | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | x | x | |
| QI Work Plan Current Year (Initial) - Kaiser, VSP | Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15 (for new year)** | 1_QIRPT_**HN**_Annual**YYYY**_QICY | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | x | x | |
| Quarterly QI Committee Minutes - Kaiser ~~Report of Findings and Actions Taken as a Result of QI Activities - Kaiser, VSP~~ | ~~Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.~~ Kaiser shall present for CalOptima review the QI Committee Meeting Minutes from the previous quarter. Presentation may be in person or by webinar. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Quarterly** | ~~1_QIRPT_HN_QTYYYY_QI Findings~~ N/A; Hardcopy minutes to be presented. | ~~HN = Health network # YYYY = 4 digit year~~ N/A | ~~hn_reporting~~ N/A | ~~PDF~~ Hardcopy | x | | | | x | ~~x~~ [Remove] | x | |
| Authorization Utilization Report | Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable).<br><br>Unused authorization reporting shall include the claims status for each referral authorized during the measurement period. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021** | 1_QIRPT_**HN_QTYYYY**_AUTH | HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| Dental Anesthesia Report | Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: 15th of the month after the end of the quarter** | 1_UMRPT_**HN_QTYYYY**_DA | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| UM Evaluation (Previous Year) | Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | x | x | x | x | | x | |
| UM Program | Health Networks shall develop a UM program description and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | x | x | x | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD

| | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| UM Work Plan (ICE) | Health Networks shall report progress towards UM program goals semi-annually. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Semi-Annually: February 15 and August 15** | 2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| UM Work Plan Current Year (Initial) | Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15 (for new year)** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY | HN = Health network # YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| Out-of-Network (OON) Requests | Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: January 25, April 25, July 25, October 25** | 1_UMRPT_**HN_QTYYYY**_OON | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| Kaiser WCM Claim Detail | Kaiser shall submit monthly report of WCM claims payment information. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 15th of every month** | Kaiser_ClaimDetail_MMDDYY | DD = 2 digit day MM = 2 digit month YYYY = 4 digit year | incoming | Excel | x | | | | x | | | x |
| Preclusion List Report for Member Notifications Only | Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Monthly: 10th of every month** | 2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month | hn_reporting | Excel | x | x | x | x | x | x | | x |
| Directed Payments File | Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Monthly: 10th of every month** | 1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | x | x | | | x |
| Kaiser WCM Rx Detail | Kaiser shall submit monthly report of WCM Rx payment information. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management | Pharmacy | **Monthly: 15th of every month** | WCM04RXCCYYMMDD | MM = 2 digit month YYYY = 4 digit year | incoming | Excel | x | | | | x | | | x |
| FDR Compliance Attestation | The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. | https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx | Office of Compliance | **Initial upon contracting; Annually thereafter** | FDR Compliance Attestation | N/A | email to compliance@caloptima.org | PDF | x | x | x | x | x | x | x | |
| Claims Timeliness Report | Health Networks shall submit a monthly claims payment performance (timeliness) report. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly 15th of every month** **Quarterly January 30, April 30, July 30, October 30** | 1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly) | HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC, OC, DB | hn_reporting | Excel | x | x | x | x | x | x | x | |
| 274 Provider Directory - Kaiser | Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS | PDMS | **Monthly 2nd of every month** | **HN**274**YYYYMMDD** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | 274/inbound/ | Text File | x | | | | x | | x | |
| Provider Termination Quarterly Report - Kaiser | Monitor Kaiser's adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: 10th of the month following the end of each quarter** | 1_CSRPT_Prov Terms_Kaiser_**YYYYMMDD** | YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | | x | | x | |
| UM Retrospective Appeal Universe | Monitor the Health Networks' handling of first level UM Provider Appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: 10th of the month following the end of each quarter** | 1_GARSRPT_Retro Auth Appeals_**HN_YYYYMMDD** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | x | x | x | x | | x | |
| Semi-Annual Site Visit Report - Kaiser | The report captures sites that received an Initial or Periodic FSR/MRR. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Semi-Annually: February 15 and August 15** | 1_QIRPT_04_**MMDDYYYY**_FSR Semi Annual Report | YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | | x | | x | |
| Kaiser Pharmacy Monitoring Report | Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management | Pharmacy | **Semi-Annually: April 1 and October 1** | Kaiser_Pharmacy_Monitoring_Report_**MMYYYY**.pdf | YYYY= 4 digit year MM = 2 digit month | Email to CalOptima Pharmacy Management Department | PDF | X | | | | x | | x | |

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# Timely and Appropriate Submission Grid - Master

Year: ~~2020~~ 2021, Release: ~~4~~ 2, Release Date: ~~10/13/20~~ TBD

| | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | ~~LINK TO TEMPLATE~~ FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: 2021, Release: 2, Release Date: TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| Annual Audit | Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Annually; Per process** | 1_AORPT_**HN_CAT** | HN = Health network # CAT = Audit Category | hn_reporting | Zip | x | x | x | x | x | x | x | |
| Claims XML Universe | Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0. | /users/Documentation Library/XML Version 2.0/Claims | Audit and Oversight | **Monthly: 2nd of every month** | 2_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | x | x | |
| Claims Universe Case Files | Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Credentialing Monthly Universe | Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight and Quality Improvement | **Health Networks and Kaiser Monthly: 2nd of every month VSP Quarterly: January 10, April 10, July 10, October 10** | 2_AORPT_QIRPT_**HN_MMYYYY**_CRED | MM = 2 digit month | hn_reporting | Excel | x | x | x | x | x | x | x | |
| Credentialing Universe Monthly Case Files | Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN_MMYYYY**_CRED_FILES | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect) | Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 2nd of every month** | 1_AORPT_**HN_MMYYYY**_NOMNC_**LB** | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect) | hn_reporting | Word | | x | x | x | | | x | |
| NOMNC Files (OneCare & OneCare Connect) | Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN_MMYYYY**_NOMNC_FILES_LB | HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | | x | x | x | | | x | |
| Provider Dispute Resolution (PDR) XML Universe | Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 2nd of every month** | 1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | x | x | |
| PDR Universe Case Files | Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN_MMYYYY**_PDR_**LB**_FILES | HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | x | x | |
| Provider Directory Universe Case Files | Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Annually, per request** | 1_AORPT_**HN**_PD_**QTYYYY** | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | PDF (zip) | x | x | x | x | | | x | |
| Utilization Management (UM) XML Universe | Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1. | /users/Documentation Library/XML Version 2.1/Authorizations | Audit and Oversight | **Monthly: 2nd of every month** | 2_XMLRPT_**HN**_UM_**YYYYMM**_##.xml | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | XML | x | x | x | x | x | | x | |
| UM Universe Case Files | Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight | Audit and Oversight | **Monthly: 10th of every month** | 1_AORPT_**HN_MMYYYY_LB**_Files | HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect) | hn_reporting | PDF | x | x | x | x | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: 2021, Release: 2, Release Date: TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser | Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/ | Behavioral Health | **Monthly: 15th of every month** | 1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY** | HN = Health network reporting #<br>YYYY= 4 digit year<br>MM = 2 digit month | hn_reporting | Excel | x | | | | x | | x | |
| Mental Health Grievances and Appeals (Medi-Cal) - Kaiser | Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report, containing mental health grievances and appeals data. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/ | Behavioral Health | **Quarterly; January 20, April 20, July 20, October 20** | Mental Health Reporting Template.xlsx<br><br>Send via email to behavioralhealth@caloptima.org | | Secure email | Excel | x | | | | x | | x | |
| Case Management Log | Health Networks shall submit monthly Case Management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly: 15th of every month** | 1_CMRPT_**HN_MMYYYY**_CM | HN = Health network reporting #<br>MM = 2 digit month<br>YYYY= 4 digit year | hn_reporting | Excel | x | | x | x | x | | x | |
| Continuity of Care (Whole-Child Model) | Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Weekly; every Tuesday by 10 am for the prior week's activity** | 1_WCMMC_**HN_YYYYMMDD**_COC | HN = Health network reporting #<br>MM = 2 digit month<br>DD - 2 digit day<br>YYYY= 4 digit year | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | x | x | | x | |
| Enhanced Monitoring Report (WCM) | Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, Regulatory Affairs | **Quarterly; 5th day after the end of the quarter** | 1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx | HN = Health network reporting #<br>YYYY= 4 digit year<br>MM = 2 digit month<br>DD - 2 digit day | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | x | x | | x | |
| Health Homes Program (HHP) Enrollment and Disenrollment Report | Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly: 10th of every month** | **HN**_HHP_Enrollment.csv | HN = Health network reporting # | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| HHP Finalized Engagement List (FEL) Return File | Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly: 10th of every month** | **HN**_HHP_ReturnFEL | HN = Health network reporting # | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| HHP Services | Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly: 10th of every month** | 1_HHPServices_**HN_YYYYMM**.csv | HN = Health network reporting #<br>YYYY= 4 digit year<br>MM = 2 digit month<br>DD - 2 digit day | Managed_HN_Reporting/HHP/Inbound | Excel | x | | | x | x | | x | |
| Implementation Audit (OneCare Connect) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_OCC_Review_**MMYYYY** | HN = Health network reporting #<br>Member_CIN = Member CIN<br>YYYY = 4 digit year<br>MM = 2 digit month | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Implementation Audit (OneCare) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_OC_Review_**MMYYYY** | HN = Health network reporting #<br>Member_CIN = Member CIN<br>YYYY = 4 digit year<br>MM = 2 digit month | OC/RevisedMOC/Inbound | PDF | | x | | x | | | x | |
| Implementation Audit (Seniors and Persons with Disabilities (SPD)) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Ongoing, per process** | **HN_Member CIN**_Review_**MMYYYY** | HN = Health network reporting #<br>Member_CIN = Member CIN<br>YYYY = 4 digit year<br>MM = 2 digit month | MediCal/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |
| Organ Transplant - Kaiser | Kaiser shall submit monthly report of members engaged in the organ transplant process. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management | **Monthly: 15th of every month** | 1_CMRPT_04_**MMYYYY**_OT | MM = 2 digit month<br>YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Annual Redetermination Files | Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_WCM_AR_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | WCM Revised MOC/Inbound | PDF | x | | | x | x | | x | |
| Individual Care Plan/Health Action Plan (ICP/HAP) bundle | Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | HN#_CIN_HHP_MMDDYYYY | HN=Health network reporting #,CIN-, MM=2 digit month, DD-2 digit day, YYYY=4 digit year (MMDDYYY=date ICP/HAP completed) | HN#HNname/MediCal/HHP MOC/Inbound | PDF | x | | | x | x | | x | |
| Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_ICP_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Interdisciplinary Care Team (ICT) Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | SPD/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: 2021, Release: 2, Release Date: TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| ICT Bundle (OneCare) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBER CIN**_ICT_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | OneCare/RevisedMOC/Inbound | PDF | | x | | x | | | x | |
| Long Term Care (LTC) ICP Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | OCC/RevisedMOC/Inbound | PDF | | | x | x | | | x | |
| Pediatric ICT Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | SPD/RevisedMOC/Inbound | PDF | x | | | x | x | | x | |
| Model of Care (MOC) SPD Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly:**<br>**6th of every month** | **HN**271**CCYYMMDD** | HN = Health network reporting #<br>CCYY= 4 digit year<br>MM = 2 digit month<br>DD = 2 digit day | SPD Revised MOC/Inbound | Pipe delimited text file | x | | | x | | | x | |
| MOC Tracking Log (OneCare Connect) | Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly:**<br>**6th of every month** | **HN**871**CCYYMMDD** | HN = Health network reporting #<br>CCYY= 4 digit year<br>MM = 2 digit month<br>DD = 2 digit day | OCC/RevisedMOC/Inbound | Pipe delimited text file | | | x | x | | | x | |
| MOC Tracking Log (OneCare) | Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly:**<br>**6th of every month** | **HN**571**CCYYMMDD** | HN = Health network reporting #<br>CCYY= 4 digit year<br>MM = 2 digit month<br>DD = 2 digit day | OneCare/RevisedMOC/Inbound | Pipe delimited text file | | x | | x | | | x | |
| MOC WCM Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly:**<br>**6th of every month** | **HN**275**CCYYMMDD** | HN = Health network reporting #<br>CCYY= 4 digit year<br>MM = 2 digit month<br>DD = 2 digit day | WCM Revised MOC/Inbound | Pipe delimited text file | x | | | x | | | x | |
| Network Staff Legend File | Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Monthly:**<br>**6th of every month** | **HN**429**YYYYMMDD** | HN = Health network reporting #<br>YYYY = 4 digit year<br>MM = 2 digit month<br>DD = 2 digit day | /RevisedMOC/Inbound | Pipe delimited text File | x | x | x | x | | | x | |
| WCM ICP Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP.<br>This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 days of HRA completion. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management (MOC) | **Ongoing, per process** | **HN_MEMBERCIN**_WCM_ICT_**MMDDYYYY** | HN = Health network reporting #<br>MEMBER CIN = CIN #<br>MM = 2 digit month<br>DD = 2 digit day<br>YYYY= 4 digit year | WCM Revised MOC/Inbound | PDF | x | | | x | x | | x | |
| DHCS WCM Report - Kaiser | Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, GARS, Utilization Management | **Monthly:**<br>**15th of every month**<br><br>**First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter** | 1_WCMMC_04_**YYYYMM**_DHCS | HN = Health network reporting #<br>YYYY= 4 digit year<br>MM = 2 digit month | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | | x | | x | |
| Population Health Management (PHM) Program Description - Kaiser | Kaiser shall develop a PHM program description and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management and Population Health Management | **Annually:**<br>**February 15** | 2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD | HN = Health network #<br>YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | | x | |
| DHCS WCM Report | Health Networks shall submit monthly report of WCM authorizations and care coordination. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management | Case Management, Utilization Management | **Monthly:**<br>**15th of every month**<br><br>**First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter** | 1_WCMMC_**HN_YYYYMM**_DHCS | HN = Health network reporting #<br>YYYY= 4 digit year<br>MM = 2 digit month | Managed_HN_Reporting/WCM/Inbound | Excel | x | | | x | | | x | |
| Claims Third Party Liability (TPL) (Medi-Cal) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly:**<br>**30th of every month** | 1_CLMRPT_**HN_MMYYYY**_TPL | HN = Health network reporting #<br>MM = 2 digit month<br>YYYY= 4 digit year | hn_reporting | Excel & PDF | x | | | x | x | | x | |
| Claims TPL (OneCare Connect) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly:**<br>**30th of every month** | 1_CLMRPT_**HN_MMYYYY**_TPL_DB | HN = Health network reporting #<br>MM = 2 digit month<br>YYYY= 4 digit year | hn_reporting | Excel & PDF | | | x | x | | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: 2021, Release: 2, Release Date: TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| DHCS Post-Payment Recovery Report (Medi-Cal Only) | Health Networks shall submit monthly report of post payment recovery data for other health coverage (OHC) claims to CalOptima. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 3rd business day of every month** | 1_MCPPR_XX_YYYYPP_SS | HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year | hn_reporting | Text File | x | | | x | x | | x | |
| Customer Service Call Log Universe | Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: January 7, April 7, July 7, October 7** | MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY** | HN = Health network # QQ = 2 digit quarter (Q1, etc) YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| Health Network Dashboard | Health Networks shall submit report of call center statistics for monthly review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Monthly: 15th of every month** | 2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard | HN = Health network # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |
| Interpreter Services Utilization Report | Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: January 30, April 30, July 30, October 30** | 2_CSRPT_QIRPT_**HN_QTYYYY**_CCS_2019 | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |
| DHCS NMT/NEMT Report - Kaiser | Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service, GARS | **Monthly: 27th of every month** | 2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY** | MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Annual Audited Financial Statements | Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Annual submission due 120 days after organization's fiscal year ends** | 1_FINRPT_**HN**_Annual**YYYY**_AAFS | HN = Health network reporting # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Incurred But Not Reported (IBNR) Documentation | Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Annual submission due 120 days after organization's fiscal year ends** | 1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements | HN = Health network reporting # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Medical Loss Ratio (MLR) | Health Networks shall submit interim and final reports of the Health Network MLR. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Interim: January - June due August 15.** <br> **Interim: January - December due February 15** <br> **Final: Annual submission of all 12 months due June 30** | 1_FINRPT_**HN_SemiAnnualYYYY**_MLR <br> 1_FINRPT_**HN_AnnualYYYY**_MLR <br> 1_FINRPT_**HN_FinalYYYY**_MLR | HN = Health network reporting # YYYY= 4 digit year | hn_reporting | Excel (using most current AFRF) | x | | x | x | | | x | |
| Risk Bearing Organization (RBO) Report | Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). | /users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance | Finance | **Annual submission due 150 days after the fiscal year ends.** <br> **Quarterly: February 15, May 15, August 15, November 15** | 1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) <br> 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly) | HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter # | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| Total Business Reports | Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance | Finance | **Quarterly: February 15, May 15, August 15, November 15** | 1_FINRPT_**HN_QTYYYY**_TBFS | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | PDF or Excel | x | x | x | x | | | x | |
| DHCS Quarterly Report - Kaiser | Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: January 23, April 23, July 23, October 23** | 1_GARSRPT_04_**QTYYYY**_DHCS | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Grievances Volume Report Kaiser | Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: January 23, April 23, July 23, October 23** | 1_GARSRPT_HMO04_QQYYYY_VOL | QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Community-Based Adult Services (CBAS) Report - Kaiser | Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS, Customer Service, Long Term Services and Supports | **Quarterly: January 23, April 23, July 23, October 23** | 3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS | QT = 2 digit Quarter # YYYY = 4 digit year | Incoming | Text File | x | | | | x | | x | |
| DHCS Data Certification Statement | Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Monthly: 25th of every month** | 1_AORPT_**HN**_Data Certification_**MMYYYY** | HN = Health network # | hn_reporting | PDF | x | | | x | x | x | x | |
| Health Network Newly Contracted Provider Training Report | Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Quarterly: January 25, April 25, July 25, October 25** | 1_HMRPT_**HN_QTYYYY**_NCT | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | x | x | |

For 2021-05-06 BOD Review Only

# Timely and Appropriate Submission Grid - Master

| Year: 2021, Release: 2, Release Date: TBD | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **REPORT NAME** | **DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)** | **FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)** | **CALOPTIMA DEPARTMENT** | **REPORT FREQUENCY** | **NAMING CONVENTION** | **NAMING CONVENTION INSTRUCTIONS** | **FTP FOLDER** | **FILE TYPE** | **MEDI-CAL** | **ONECARE** | **ONECARE CONNECT** | **Health Networks (Except Kaiser)** | **Kaiser** | **VSP** | **Oversight** | **Reimbursement** |
| Primary Care Provider (PCP) Upload File | Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Bi-monthly: 10th and 25th of every month** | **HN204JJJ** | HN = Health network reporting # JJJ = Julian Date | hn_reporting | Excel | x | | | x | | | x | |
| DHCS Supplemental Data – Kaiser | Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/IS | IS | **Monthly; 15th of every month** | CalOptima_KSR_PRD_Supplementals_[yyyymm].txt | YYYY= 4 digit year MM = 2 digit month | Incoming | Text File | x | | | | x | | x | |
| Vision Service Plan (VSP) Provider Roster | VSP shall submit monthly report of VSP providers for the print and online provider directories. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS | PDMS | **Monthly: 15th of every month** | VSP_Medicaid_CA_Orange_County_Provider_Listing **_YYYYMMDD** | HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day | | Excel | x | | | | | x | x | |
| Health Education Calendar Kaiser | Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually: January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HECALENDAR | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Health Education Individual Encounters - Kaiser | Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HEIE | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Word | x | | | | x | | x | |
| Health Education Other Encounters - Kaiser | Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Semi-Annually January 31 and July 31** | 1_DMRPT_04_**MMYYYY**_HEOE | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Word | x | | | | x | | x | |
| Perinatal Support Services (PSS) Encounters - Kaiser | Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management | Population Health Management | **Monthly: 15th of every month** | 1_DMRPT_04_**MMYYYY**_PSS_Services | HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year | hn_reporting | Excel | x | | | | x | | x | |
| Access and Availability Report - Kaiser | Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Analytics | Quality Analytics | **Annually: February 15** | 1_MDMRPT_04_Annual**YYYY**_Access | YYYY = 4 digit year | hn_reporting | Excel or Word or PDF | x | | | | x | | x | |
| Quality Improvement (QI) Evaluation (Previous Year) - Kaiser, VSP | Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15** | 1_QIRPT_**HN**_Annual**YYYY**_QIE | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | x | x | |
| QI Program - Kaiser, VSP | Kaiser shall develop an annual QI report and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15** | 1_QIRPT_**HN**_Annual**YYYY**_QIP | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | | | | x | x | x | |
| QI Work Plan - Kaiser, VSP | Kaiser shall report progress towards QI program goals semi-annually. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Semi-Annually: February 15 and August 15** | 1_QIRPT_**HN**_SemiAnnual**YYYY**_QI | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | x | x | |
| QI Work Plan Current Year (Initial) - Kaiser, VSP | Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Annually: February 15 (for new year)** | 1_QIRPT_**HN**_Annual**YYYY**_QICY | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | | | | x | x | x | |
| Quarterly QI Committee Minutes - Kaiser | Kaiser shall present for CalOptima review the QI Committee Meeting Minutes from the previous quarter. Presentation may be in person or by webinar. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Quarterly** | N/A; Hardcopy minutes to be presented. | N/A | N/A | Hardcopy | x | | | | x | | x | |
| Authorization Utilization Report | Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable).<br><br>Unused authorization reporting shall include the claims status for each referral authorized during the measurement period. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021** | 1_QIRPT_**HN_QTYYYY**_AUTH | HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| Dental Anesthesia Report | Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: 15th of the month after the end of the quarter** | 1_UMRPT_**HN_QTYYYY**_DA | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| UM Evaluation (Previous Year) | Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | x | x | x | x | | x | |
| UM Program | Health Networks shall develop a UM program description and submit to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP | HN = Health network # YYYY = 4 digit year | hn_reporting | PDF or Word | x | x | x | x | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid - Master

Year: 2021, Release: 2, Release Date: TBD

| | | | | | | | | | Line of Business | | | Report Requirement Indicator | | | Report Type | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORT NAME | DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements) | FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK) | CALOPTIMA DEPARTMENT | REPORT FREQUENCY | NAMING CONVENTION | NAMING CONVENTION INSTRUCTIONS | FTP FOLDER | FILE TYPE | MEDI-CAL | ONECARE | ONECARE CONNECT | Health Networks (Except Kaiser) | Kaiser | VSP | Oversight | Reimbursement |
| UM Work Plan (ICE) | Health Networks shall report progress towards UM program goals semi-annually. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Semi-Annually: February 15 and August 15** | 2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY | HN = Health network # YYYY = 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| UM Work Plan Current Year (Initial) | Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Annually: February 15 (for new year)** | 2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY | HN = Health network # YYYY= 4 digit year | hn_reporting | Excel | x | x | x | x | x | | x | |
| Out-of-Network (OON) Requests | Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt | Utilization Management | **Quarterly: January 25, April 25, July 25, October 25** | 1_UMRPT_**HN_QTYYYY**_OON | HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year | hn_reporting | Excel | x | | | x | x | | x | |
| Kaiser WCM Claim Detail | Kaiser shall submit monthly report of WCM claims payment information. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly: 15th of every month** | Kaiser_ClaimDetail_MMDDYY | DD = 2 digit day MM = 2 digit month YYYY = 4 digit year | incoming | Excel | x | | | | x | | | x |
| Preclusion List Report for Member Notifications Only | Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Monthly: 10th of every month** | 2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month | hn_reporting | Excel | x | x | x | x | x | x | | x |
| Directed Payments File | Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR | HNR | **Monthly: 10th of every month** | 1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | x | x | | | x |
| Kaiser WCM Rx Detail | Kaiser shall submit monthly report of WCM Rx payment information. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management | Pharmacy | **Monthly: 15th of every month** | WCM04RXCCYYMMDD | MM = 2 digit month YYYY = 4 digit year | incoming | Excel | x | | | | x | | | x |
| FDR Compliance Attestation | The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. | https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx | Office of Compliance | **Initial upon contracting; Annually thereafter** | FDR Compliance Attestation | N/A | email to compliance@caloptima.org | PDF | x | x | x | x | x | x | x | |
| Claims Timeliness Report | Health Networks shall submit a monthly claims payment performance (timeliness) report. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting | Claims | **Monthly 15th of every month** **Quarterly January 30, April 30, July 30, October 30** | 1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly) | HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC, OC, DB | hn_reporting | Excel | x | x | x | x | x | x | x | |
| 274 Provider Directory - Kaiser | Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS | PDMS | **Monthly 2nd of every month** | **HN**274**YYYYMMDD** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | 274/inbound/ | Text File | x | | | | x | | x | |
| Provider Termination Quarterly Report - Kaiser | Monitor Kaiser's adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service | Customer Service | **Quarterly: 10th of the month following the end of each quarter** | 1_CSRPT_Prov Terms_Kaiser_**YYYYMMDD** | YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | | x | | x | |
| UM Retrospective Appeal Universe | Monitor the Health Networks' handling of first level UM Provider Appeals. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS | GARS | **Quarterly: 10th of the month following the end of each quarter** | 1_GARSRPT_Retro Auth Appeals_**HN_YYYYMMDD** | HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | x | x | x | x | | x | |
| Semi-Annual Site Visit Report - Kaiser | The report captures sites that received an Initial or Periodic FSR/MRR. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement | Quality Improvement | **Semi-Annually: February 15 and August 15** | 1_QIRPT_04_**MMDDYYYY**_FSR Semi Annual Report | YYYY= 4 digit year MM = 2 digit month DD - 2 digit day | hn_reporting | Excel | x | | | | x | | x | |
| Kaiser Pharmacy Monitoring Report | Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates. | /users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management | Pharmacy | **Semi-Annually: April 1 and October 1** | Kaiser_Pharmacy_Monitoring_Report_**MMYYYY**.pdf | YYYY= 4 digit year MM = 2 digit month | Email to CalOptima Pharmacy Management Department | PDF | X | | | | x | | x | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Annual Audit | Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements.<br><br>The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable:<br><br>• Access & Availability<br>• Care Delivery Model<br>• Claims<br>• Compliance<br>• Credentialing<br>• Cultural & Linguistics<br>• Customer Service<br>• Encounters<br>• Information Systems<br>• Mailroom Process<br>• Marketing<br>• Medi-Cal Addendum<br>• Member Grievances & Appeals<br>• Network Management<br>• Provider Network Contracting<br>• Provider Relations<br>• Quality Improvement<br>• Sub-Contractual<br>• Translation Services<br>• Utilization Management<br>• Whole Child Model | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>APL 17-004: Sub-Contractual Relationships and Delegation | Annually:<br>per process | X | X | X | X | X | X |
| Claims XML Universe | Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0.<br><br>The report includes the following:<br><br>• Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process)<br>• CalOptima Line of Business (LOB)<br>• Claim number, form type, bill type in UB04, admission code, place of service name and code<br>• Authorization number<br>• Was claim adjusted and clean<br>• Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy HH.2015: Health Network Claims Processing<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>5.1.9<br>5.1.9.2<br>5.1.10 | Monthly:<br>2nd of every month | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Beneficiary name, Client Identification Number (CIN), threshold language<br>• Requestor type, receipt date and time<br>• Date and time of additional information requested (AIR)<br>• Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status<br>• Rendering provider name, NPI, Tax ID, specialty, contracted status<br>• Medical necessity denials<br>• Date and time claim received, loaded in system, decision made, claim redirected<br>• Payment information method, number, print date and time, transfer date and time<br>• Mail date and time of written notification to member and provider<br>• Decision maker name, title and credentials<br>• International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting<br>• Date of service<br>• Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount<br>• Paid revenue code, description, and CPT/HCPC<br>• Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description<br>• Paid reason for CPT/HCPC change<br>• Decision type and decision denial reason | DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4<br><br>Medicare Managed Care Manual Chapter 11, Section 110.2<br><br>Title 42, Code of Federal Regulations (CFR), Sections:<br>422.520 (a)<br>447.45 (d) | | | | | | | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

<table>
<tr><th rowspan="2">REPORT NAME</th><th rowspan="2">DESCRIPTION/REQUIREMENT</th><th rowspan="2">CITATION</th><th rowspan="2">REPORT FREQUENCY</th><th colspan="3">LINE OF BUSINESS</th><th colspan="3">REPORT REQUIREMENT INDICATOR</th></tr>
<tr><th>Medi-Cal</th><th>OneCare</th><th>OneCare Connect</th><th>Health Networks (Except Kaiser)</th><th>Kaiser</th><th>VSP</th></tr>
<tr><td>Claims Universe Case Files</td><td>Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br><u>Paid Claims:</u><br>• Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date)<br>• Authorization, if applicable<br>• Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable<br>• Proof of check clearing (bank statements or copy of cancelled check)<br><br><u>Denied/Contested Claims:</u><br>• Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date)<br>• Eligibility print screen if contested/denied for eligibility<br>• System notes pertaining to claim<br>• If applicable, denial letters for member liability denials and any supporting documents used to determine the denial<br>• RA/EOB with interest, if applicable<br><br><u>Adjustments:</u><br>• Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt)<br>• Original RA/EOB showing payment or denial<br>• Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.)<br>• Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.)<br>• All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development<br>• RA/EOB with applicable interest<br>• Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim</td><td>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy HH.2015: Health Network Claims Processing<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>5.1.9<br>5.1.9.2<br>5.1.10<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.520 (a)<br>447.45 (d)</td><td>Monthly:<br>10th of every month</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Credentialing Monthly Universe | Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.<br><br>The report includes the following:<br><br>• Health Network name, reporting month and year<br>• Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report<br>• Data ID (IC/RC/TM)<br>• CalOptima program (Medi-Cal, OneCare, OneCare Connect)<br>• Individual practitioner name, license number and type<br>• Contract type and primary contracted specialty<br>• Current and previous credentialing decision dates<br>• Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date<br>• Current facility site review date<br>• Current, signed attestation date<br>• Termination date and reasons for termination<br>• Date Change Termination (CT) form was submitted | NCQA Standards, Credentialing/Recredentialing:<br>CR3<br>CR4<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment<br><br>CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities<br><br>CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.10.5<br>2.16.3.3<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions:<br>6<br>12<br><br>Medicare Managed Care Manual:<br>Chapter 6, Section 60.3<br>Chapter 11, Section 110.2 | Health Networks and Kaiser<br>Monthly:<br>2nd of every month<br><br>VSP<br>Quarterly:<br>January 10, April 10, July 10, October 10 | X | X | X | X | X | X |
| Credentialing Universe Monthly Case Files | Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br>Initial Credentialing<br>• Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter<br>• File checklist<br>• Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization)<br>• License verification<br>• Copy of DEA certificate or verification of DEA registration<br>• Work history, and education and training verification<br>• Board certification verification, as applicable | NCQA Standards, Credentialing/Recredentialing:<br>CR3<br>CR4<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment<br><br>CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities | Monthly:<br>10th of every month | X | X | X | X | X | X |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage<br>• Copy of current malpractice/professional liability policy<br>• National Practitioner Data Bank query<br>• State sanctions or restriction on licensure verification<br>• Medicare/Medicaid sanction verification<br>• Office of Inspector General (OIG) review<br>• System for Award Management (SAM) review<br>• Medi-Cal Suspended and Ineligible review<br>• Medicare opt-out review<br>• CMS Preclusion List review<br>• Current Facility Site Review, if applicable<br>• Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners)<br>• Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners<br><br>Recredentialing<br>• Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter<br>• Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter<br>• File checklist<br>• Performance monitoring documentation<br>• Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization)<br>• License verification<br>• Copy of DEA certificate or verification of DEA registration<br>• Board certification verification, as applicable<br>• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage<br>• Copy of current malpractice/professional liability policy<br>• National Practitioner Data Bank query<br>• State sanctions or restriction on licensure verification<br>• Medicare/Medicaid sanction verification<br>• Office of Inspector General (OIG) review<br>• System for Award Management (SAM) review<br>• Medi-Cal Suspended and Ineligible review<br>• Medicare opt-out review<br>• CMS Preclusion List review<br>• Current Facility Site Review, if applicable<br>• Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners)<br>• Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners | CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners<br><br>CalOptima Policy GG.1619: Delegation Oversight<br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.10.5<br>2.16.3.3<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions:<br>6<br>12<br><br>Medicare Managed Care Manual:<br>Chapter 6, Section 60.3<br>Chapter 11, Section 110.2 | | | | | | | |
| Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect) | Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.<br><br>The report includes the following:<br><br>• Member identifier, medical record number, and facility service type<br>• Date of termination request/notice and date of actual termination | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.9<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2 | Monthly:<br>2nd of every month | | X | X | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt<br>• Date of discharge | Title 42, CFR, Sections:<br>405.1200 (b)(1) & (2)<br>422.624 (b)(1) and (2) | | | | | | | |
| NOMNC Files (OneCare & OneCare Connect) | Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>NOMNC files include the following:<br><br>• Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services<br>• Date of termination request<br>• Date of actual termination (including date, time and name of provider making the request)<br>• Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services)<br>• Member/member's representative notified of appeal rights<br>• Date of termination request/notification signed by the member/member's representative<br>• Copy of signed NONMC letter<br>• Date of discharge<br><br>If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required:<br>• Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice)<br>• Proof of letter mailed on same date of call made to member's representative<br>• If provider is unable to reach member's representative by phone, provide proof of the following:<br>o Certified mail receipt with return receipt request<br>o Date someone at the representative's address signs or refuses to sign the letter<br>o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.9<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>405.1200 (b)(1) & (2)<br>422.624 (b)(1) and (2) | Monthly:<br>10th of every month | | X | X | X | | |
| Provider Dispute Resolution (PDR) XML Universe | Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0.<br><br>The report includes the following:<br><br>• Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect)<br>• Unique ID number used to track authorization request<br>• Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR<br>• Check number used to pay overturned PDR request, and date and time check was mailed<br>• Date and time the written notification was provided to the provider<br>• Name and title of the decision maker of the PDR request | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 | Monthly:<br>2nd of every month | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received<br>• Billing provider's name, NPI number, tax ID number, specialty, and whether contracted<br>• Claim number of the original claim being appealed, and decision date and time of the original claim being appealed<br>• Member's name, CIN, and preferred language<br>• ICD type and diagnosis code<br>• Start date and end date of services rendered<br>• Billed revenue code, CPT/HCPC code, and modifier<br>• Billed units and billed amount<br>• Paid amount (excluding interest), withhold amount, and paid interest amount<br>• Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason<br>• Adjustment code and description | Health and Safety Code (HSC), Section 1367:<br>(h)(1)<br>(2)<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 28, California Code of Regulations (CCR), Section 1300.71.38:<br>(b)<br>(c)<br>(d) | | | | | | | |
| PDR Universe Case Files | Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br>• Copy of original claim, and received date (if electronic claim, a print screen showing received date)<br>• Original RA/EOB showing payment or denial<br>• Provider dispute request along with pertinent documents submitted, and date received<br>• All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development<br>• Acknowledgement letter, and resolution letter sent to provider<br>• EOB showing payment with applicable interest, if original decision of payment denial is overturned<br>• Proof of check clearing (bank statements or copy of cancelled check) if payment is issued | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2<br><br>HSC, Section 1367:<br>(h)(1)<br>(2)<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 28, CCR, Section 1300.71.38:<br>(b)<br>(c)<br>(d) | Monthly:<br>10th of every month | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Provider Directory Universe Case Files | Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results.<br><br>The Provider Directory file review is based on a signed and dated provider attestation that includes the following:<br>• Provider name, California license number, and gender<br>• Address (office locations), office days and hours, day phone number, and after-hours phone number<br>• Administrative email address, or office fax number (if no administrative email available)<br>• Languages spoken by provider and staff<br>• Primary specialty (i.e. dermatology, internal medicate, etc.)<br>• Accepting new patients (i.e., open or closed panel), and age restrictions<br>• Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital)<br>• Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP)<br>• Programs (i.e. Medi-Cal, OneCare, OneCare Connect)<br>• Provider type in this network (i.e. Primary Care Provider, Specialist)<br>• Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number<br>• Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment."<br>• Designated space for printed name, signature and date for the provider office manager or equivalent staff | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Health Network Contract, Section 7.10<br><br>CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.17.5.11<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4<br><br>HSC, Section 1367.27<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Section 438.10 (h) | Annually, per request | X | X | X | X | | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Utilization Management (UM) XML Universe | Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1.<br><br>The report includes the following:<br><br>• Version, as of date, entry identification (ID), and line of business (LOB) for this authorization<br>• ID number used to track the authorization request (AR), and type of AR<br>• Whether authorization is for Part B or physician administered drugs and/or administration<br>• Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist<br>• Method AR was received, and authorization number related to AR<br>• CMS place of service code and name<br>• Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network)<br>• Member name, CIN, and preferred language<br>• AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator)<br>• Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB)<br>• Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received<br>• Requesting provider/group/facility name, NPI, tax ID number, and whether contracted<br>• Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted<br>• Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted<br>• Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit)<br>• Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date<br>• Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe<br>• If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe<br>• If a request to expedite was made after the original request, identify requestor of subsequent request to expedite<br>• Whether a timeframe extension was taken<br>• Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member<br>• The method used to initially notify the requesting provider of the decision of authorization request<br>• Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream<br>• Whether the review was completed by a physician or other appropriate health care professional<br>• Name, job title, and credentials of the decision maker of the AR<br>• Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description<br>• Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units<br>• Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units<br>• Determination of the requested service<br>• Reason for the denial or modification of the requested service | NCQA Standards, Utilization Management, UM5<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1541: Utilization Management Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.6.3<br>2.11.7<br>2.11.9<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions:<br>2<br>3<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.572(a) & (b)<br>422.568 (b)(1)<br><br>Medicare Part C Reporting Requirements, Section VI | Monthly:<br>2nd of every month | X | X | X | X | X | |

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| UM Universe Case Files | Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>UM case files include the following documentation:<br><br>Medi-Cal<br>• Approval file checklist includes all medical records attached to file and transaction log<br>• Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log<br>• Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log<br><br>OneCare<br>• Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available<br>• Denial file checklist includes denial letter, all medical records attached to the file and transaction log<br><br>OneCare Connect<br>• Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available<br>• Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available | NCQA Standards, Utilization Management, UM5<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1541: Utilization Management Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.6.3<br>2.11.7<br>2.11.9<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions:<br>2<br>3<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.572(a) & (b)<br>422.568 (b)(1) | Monthly:<br>10th of every month | X | X | X | X | X | |
| Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser | Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.<br><br>The report includes the following:<br><br>• Plan code, name, county and reporting period<br>• Number of CDE referrals<br>• Number of referrals determined appropriate for CDE<br>• Number of CDE completed<br>• Number of CDE appointments scheduled within and outside timely access<br>• Number of CDE not scheduled but offered appointment<br>• Number of CDE with appointment not yet scheduled<br>• Comments | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 | Monthly:<br>15th of each month | X | | | | X | |
| Mental Health Grievances and Appeals (Medi-Cal) - Kaiser | Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data.<br><br>The report includes the following: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 | Quarterly:<br>January 20, April 20, July 20, October 20 | X | | | | X | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Plan code, name, county, reporting quarter and total number of members<br>• Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code<br>• Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description<br>• Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period<br>• Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for<br>• Average number of days taken to deny requests<br>• Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description<br>• Number of COC requests in process and comments | | | | | | | | |
| Case Management Log | Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services.<br><br>The report includes the following:<br><br>• Member name, CIN, date of birth, and program<br>• Diagnosis and ICD-10 code (qualifying member for case management)<br>• Referral/data source to case management, date opened, and date closed<br>• Case management level, status change reason, and complex case trigger<br>• Additional programs to which member has been referred<br>• Special program to which member is enrolled, or any special needs of member | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 1<br>Attachment 11, Provision 2<br><br>APL 17-004: Subcontractual Relationships and Delegation<br><br>NCQA Standards, Population Health Management:<br>PHM5<br>PHM7 | Monthly:<br>15th of every month | X | | X | X | X | |
| Continuity of Care (Whole-Child Model) | Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.<br><br>The report includes the following:<br>• Requestor type, date of request, and request type<br>• Member name and CIN<br>• COC begin processing date and date of decision<br>• COC completion date (including member notification) and COC expiration date<br>• Requested provider NPI and provider type<br>• Decision outcome, denial reason, and explanation of other reasons<br>• Next steps taken for incomplete requests | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 10 | Weekly:<br>Every Tuesday by 10 am for the prior week's activity | X | | | X | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Enhanced Monitoring Report (WCM) | Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.<br><br>The report includes the following:<br><br>Health Networks (including Kaiser):<br>• Describe any challenges with care coordination and Health Network's role in overcoming barriers<br>• Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions<br>• For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes<br><br>Kaiser Only:<br>• Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP<br>• Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 10 | Quarterly:<br>5th day after the end of the quarter | X | | | X | X | |
| Health Homes Program (HHP) Enrollment and Disenrollment Report | Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.<br><br>The report includes the following:<br><br>• Member name, CIN, and date of birth<br>• Whether HHP enrolled member was externally referred<br>• HHP disenrollment date and reason<br>• Whether member is homeless/at risk for homelessness, or received housing services during reporting period<br>• Whether member was homeless at any point during enrollment in HHP<br>• Whether member is no longer homeless as of the last day of reporting period<br>• File create date | DHCS HHP Program Guide<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |
| HHP Finalized Engagement List (FEL) Return File | Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.<br><br>The Health Network response file includes the following:<br><br>• Excluded because not eligible-well managed: Y/N<br>• Excluded because declined to participate: Y/N<br>• Excluded because of unsuccessful engagement: Y/N<br>• Excluded because of duplicative program: Y/N<br>• Excluded because of unsafe behavior or environment: Y/N<br>• Excluded because not enrolled in Medi-Cal at MCP: Y/N<br>• Enrollment date (if applicable) | DHCS HHP Program Guide<br><br>CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| HHP Services | Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.<br><br>The report includes the following:<br>• Claim line ID<br>• Health Network ID, claim number, claim line number<br>• Member name and CIN<br>• Date of service and service provided<br>• Claim or encounter received date<br>• Whether an adjustment, and previous claim number<br>• Rendering provider name and NPI<br>• Billing provider name, NPI, and Tax ID<br>• Billed CPT code and modifier, and primary diagnosis<br>• Units billed and provider billed amount<br>• Paid amount, and adjustment code<br>• Fee-for-service or capitated claim<br>• Check or EFT transaction number<br>• Optional user defined fields | DHCS HHP Program Guide<br><br>CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |
| Implementation Audit (OneCare Connect) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>DPL 15-001: ICP and ICT Requirements, Section A. Care Plans<br><br>Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections:<br>CA1.5<br>CA1.6<br><br>CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements | Ongoing, per process | | | X | X | | |
| Implementation Audit (OneCare) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Medicare Managed Care Manual, Chapter 5 | Ongoing, per process | | X | | X | | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Implementation Audit (Seniors and Persons with Disabilities (~~or~~ SPD)) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | X | |
| Organ Transplant – Kaiser | Kaiser shall submit monthly report of members engaged in the organ transplant process.<br><br>The report includes the following:<br><br>• Member name, CIN, and date of birth<br>• Transplant related diagnosis and transplant type<br>• DHCS-approved transplant center where member will be transplanted<br>• Date the Health Network notified CalOptima of member's potential transplant status<br>• Current transplant phase and the date the phase began<br>• Date member is listed for transplant at DHCS-approved transplant center<br>• Date member was last contacted regarding case management/coordination care issues<br>• Date the transplant case is closed and reason for case closure<br>• Case manager name<br>• Additional comments to clarify report | APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4 | Monthly:<br>15th of every month | X | | | | X | |
| Annual Redetermination Files | Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.<br><br>The report includes the following:<br><br>• Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination.<br>• WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date. | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Section 6<br>Attachment 11, Section 10 | Ongoing, per process | X | | | X | X | |
| Individual Care Plan/Health Action Plan (ICP/HAP) bundle | Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.<br><br>The report includes the following:<br><br>• Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills.<br>• Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals. | Medi-Cal Health Homes Program Guide<br><br>APL 18-012: Health Homes Program Requirements | Ongoing, per process | X | | | X | X | |

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Clinical assessments/case management notes | | | | | | | | |
| Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections:<br>CA 1.1 - CA 1.5<br><br>OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>Medicare Managed Care Manual, Chapter 5, Sections:<br>20.2.1<br>2.C and D<br><br>DPL 15-001: ICP and ICT Requirements | Ongoing, per process | | | X | X | | |
| Interdisciplinary Care Team (ICT) Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | X | |
| ICT Bundle (OneCare) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Medicare Managed Care Manual, Chapter 5 | Ongoing, per process | | X | | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Long Term Care (LTC) ICP Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Final ICP that includes assessments, interventions, and goals set by the facility<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>DPL 15-001: ICP and ICT Requirements<br><br>CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2 | Ongoing, per process | | | X | X | | |
| Pediatric ICT Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT notes/minutes, participants invited according to member's needs, and ICT attendees<br>• Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Copy of Care Planning Letter sent to Member with date mailed and preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | <u>X</u> | |
| Model of Care (MOC) SPD Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed)<br><br>Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM. | DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 | Monthly:<br>6th of every month | X | | | X | ~~X~~ | |
| MOC Tracking Log (OneCare Connect) | Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number | Cal MediConnect 3-Way Contract, Sections:<br>2.5.2.7<br>2.5.2.7.1 | Monthly:<br>6th of every month | | | X | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Care Management Level (CML)<br>• Reason for change in CML (if changed) | | | | | | | | |
| MOC Tracking Log (OneCare) | Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed) | Title 42, CFR, Section 422.101(f) | Monthly:<br>6th of every month | | X | | X | | |
| MOC WCM Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed)<br><br>Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM. | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) | Monthly:<br>6th of every month | X | | | X | | |
| Network Staff Legend File | Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Staff name, number (unique for each individual PCC or CC, phone number, and email<br>• For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments<br>• Model of Care (MOC) training received<br>• PCC training received and PCC staffing ratio met<br>• Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans<br>• Type of licensed staff or non-licensed CC staff<br>• Attestation from Manager/Director (name and title) to report information | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.5.2.7<br>2.5.2.7.1<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2<br><br>Title 42, CFR, Section 422.101(f) | Monthly:<br>6th of every month | X | X | X | X | | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| WCM ICP Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) | Ongoing, per process | X | | | X | X | |
| DHCS WCM Report - Kaiser | Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME<br>• Number of members identified as high risk and as low risk<br>• Number of WCM assessments completed to date for high risk members and for low risk members<br>• Number of WCM ICP completed to date for high risk members<br>• Number of WCM eligible members with diagnosis requiring a referral to SCC to date<br>• Number of WCM eligible members who have been seen by SCC to date<br>• Number of WCM member discharged from hospital to date<br>• Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date<br>• Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider<br>• Number of other WCM grievances and summary of such grievances<br>• Number of WCM appeals and summary of appeals | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4<br>Attachment 11, Provision 10 | Monthly:<br>15th of every month | X | | | | X | |
| Population Health Management (PHM) Program Description - Kaiser | Kaiser shall develop a PHM program description and submit to CalOptima for review.<br><br>The report includes the following:<br><br>• Quantitative results for relevant clinical, cost/utilization and experience measures<br>• Comparison of results with a benchmark | NCQA Standards, Population Health Management, PHM7 | Annually:<br>February 15th | X | | | | X | |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS WCM Report | Health Networks shall submit monthly report of WCM authorizations and care coordination.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME<br>• Number of members identified as high risk and as low risk<br>• Number of WCM assessments completed to date for high risk members and for low risk members<br>• Number of WCM ICP completed to date for high risk members<br>• Number of WCM eligible members with diagnosis requiring a referral to SCC to date<br>• Number of WCM eligible members who have been seen by SCC to date<br>• Number of WCM member discharged from hospital to date<br>• Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11 Provision 10 | Monthly:<br>15th of every month | X | | | X | | |
| Claims Third Party Liability (TPL) (Medi-Cal) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.<br><br>The report includes the following:<br><br>• Member name, ID number, date of birth, and date of death (if applicable)<br>• Contractor's name (CalOptima)<br>• Provider name(s), and date of service<br>• Diagnosis code(s) and description of illness or injury<br>• Procedure codes(s) and description of services rendered<br>• Amount subcontractor or out-of-plan Provider billed, if applicable<br>• Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable<br>• Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable | CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL)<br><br>APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements<br><br>Cal MediConnect 3-Way Contract, Section 5.1.13.1<br><br>DHCS Medi-Cal Contract, Exhibit E, Attachment 2 | Monthly:<br>30th of every month | X | | | X | X | |
| Claims TPL (OneCare Connect) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.<br><br>The report includes the following:<br><br>• Member name, ID number, date of birth, and date of death (if applicable)<br>• Contractor's name (CalOptima)<br>• Provider name(s), and date of service<br>• Diagnosis code(s) and description of illness or injury<br>• Procedure code(s) and description of services rendered<br>• Amount subcontractor or out-of-plan provider billed, if applicable<br>• Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable<br>• Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable | CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability<br><br>Title 42, CFR, Sections:<br>405.378<br>411.24<br>422.108<br>423.462<br><br>CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights"<br><br>Cal MediConnect 3-Way Contract, Section 5.1.13 | Monthly:<br>30th of every month | | | X | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS Post-Payment Recovery Report (Medi-Cal Only) | Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima.<br><br>The report includes the following:<br><br>• Project type (Third Part Liability "TPL")<br>• Name of Provider billing the claim, and provider tax ID number<br>• Claim type (What kind of claim was submitted, Facility, Professional, etc.)<br>• Member name, date of birth, ID number, and social security number<br>• Transaction control number (claim number)<br>• Begin date and end date of service<br>• Coordinated care organization bill amount (amount billed to TPL/Provider)<br>• Coordinated care organization paid amount (amount paid to the Provider)<br>• Bill date (date the claim was billed to the TPL)<br>• Remit amount (amount recovered from the TPL)<br>• Claim date of remit (date the claim was paid or denied by TPL)<br>• Check number related to remit amount<br>• Other insurance carrier name (name of the TPL that was billed)<br>• Claim status (disposition of the claim, paid, denied, open, etc.)<br>• Denial reason (the reason the claim was denied by the TPL) | APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage | Monthly:<br>3rd business day of every month | X | | | X | X | |
| Customer Service Call Log Universe | Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.<br><br>The report includes the following:<br><br>• File ID number, and line of business<br>• Member name and cardholder ID (assigned by HN to identify member)<br>• Date and time the call was received<br>• Category of the call and detailed description of the call<br>• Detailed description of the outcome/resolution of the call<br>• Date and time the call was resolved<br>• Customer Service Representative name who handled the call<br>• Member's language | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 13, Provision 2<br>Attachment 14, Provision 1<br>Attachment 14, Provision 2<br><br>Health and Safety Code (HSC), Section 1368(a)(1)<br><br>Title 28, CCR, Section 1300.68(a)<br><br>Cal MediConnect 3-Way Contract, Section 2.14<br><br>Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance<br><br>NCQA Element MED12D: Providing Information to Medicaid Members in the Practitioner Directory (Kaiser) | Quarterly:<br>January 7, April 7, July 7, October 7 | X | X | X | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Health Network Dashboard | Health Networks shall submit report of call center statistics for monthly review.<br><br>The report includes the following:<br><br>• Total number of calls, average speed of answer, and average length of call in seconds<br>• Service levels (percentage of incoming calls answered within 30 seconds)<br>• Average speed to answer member services telephone calls with a live voice<br>• Abandonment rate (percentage of incoming calls disconnected)<br>• Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services)<br>• Number of calls by language | CalOptima Health Network Contract, Sections:<br>3.5<br>7.1<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3 | Monthly;<br>15th of every month | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Interpreter Services Utilization Report | Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.<br><br>The report includes the following:<br><br>• Requests for interpreter services by language (number of requests received, and number of requests fulfilled)<br>• Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff<br>• Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff<br>• Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted) | DHCS Medi-Cal Contract, Exhibit A, Attachment 6<br><br>Cal MediConnect 3-Way Contract, Section 2.11.1.2.2 | Quarterly:<br>January 30, April 30, July 30, October 30 | X | X | X | X | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS NMT/NEMT Report – Kaiser | Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above<br>• Number of NMT denials<br>• Number of NMT and NEMT calls<br>• Number of NMT and NEMT grievances, and grievance reasons<br>• NMT/NEMT reporting comments | APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10<br><br>Welfare and Institutions Code, Section 14132 | Monthly:<br>27th of every month | X | | | | X | |
| Annual Audited Financial Statements | Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).<br><br>Audited financial statements include the following:<br><br>• Letters to management, and incurred but not reported (IBNR) documentation<br>• Consolidated corporate audited financial statements (if Health Network is part of a larger entity) | CalOptima Policy FF.3001: Financial Reporting | Annual submission due 120 days after organization's fiscal year ends | X | X | X | X | | |

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | | REPORT REQUIREMENT INDICATOR | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures | | | | | | | | |
| Incurred But Not Reported (IBNR) Documentation | Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report.<br><br>The IBNR documentation includes the following:<br><br>• Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims<br>• Supporting documentation for the IBNR calculation | CalOptima Policy FF.3001 Financial Reporting | Annual submission due 120 days after organization's fiscal year ends | X | X | X | X | | |
| Medical Loss Ratio (MLR) | Health Networks shall submit interim and final reports of the Health Network MLR.<br><br>MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic).<br><br>SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template. | CalOptima Policy FF.3001: Financial Reporting | Interim: January - June due August 15<br><br>Interim: January - December due February 15<br><br>Final: Annual submission of all 12 months due June 30 | X | | X | X | | |
| Risk Bearing Organization (RBO) Report | Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).<br><br>RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3. | CalOptima Policy FF.3001: Financial Reporting | Annual submission due 150 days after the fiscal year ends<br><br>Quarterly: February 15, May 15, August 15, November 15 | X | X | X | X | | |
| Total Business Reports | Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.<br><br>Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures. | CalOptima Policy FF.3001: Financial Reporting | Quarterly: February 15, May 15, August 15, November 15 | X | X | X | X | | |
| DHCS Quarterly Report - Kaiser | Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Year, quarter, plan code, member CIN<br>• Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other | CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3<br><br>APL 14-013: Grievance Report Template | Quarterly: January 23, April 23, July 23, October 23 | X | | | | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS: Medi-Cal | LINE OF BUSINESS: OneCare | LINE OF BUSINESS: OneCare Connect | REPORT REQUIREMENT INDICATOR: Health Networks (Except Kaiser) | REPORT REQUIREMENT INDICATOR: Kaiser | REPORT REQUIREMENT INDICATOR: VSP |
|---|---|---|---|---|---|---|---|---|---|
| | • For the other category, grievance type(s) must be defined by HN<br>• Whether grievance was resolved (in favor of member or HN) or unresolved | APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments | | | | | | | |
| Grievances Volume Report - Kaiser | Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other<br>• Total of all grievance types | CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process<br><br>DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3 | Quarterly:<br>January 23, April 23, July 23, October 23 | X | | | | X | |
| Community-Based Adult Services (CBAS) Report - Kaiser | Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, reporting quarter<br>• Number of requests for CBAS, and number of CBAS Providers<br>• Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services<br>• Average number of days between CBAS request and notice of eligibility<br>• Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center<br>• Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances<br>• Number of CBAS appeals approved, denied, and withdrawn<br>• Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS<br>• Number of CBAS complaint calls from member and from provider<br>• Explanations and summary of CBAS complaints<br>• CBAS reporting comments | CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6 | Quarterly:<br>January 23, April 23, July 23, October 23 | X | | | | X | |
| DHCS Data Certification Statement | Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.<br><br>The most current template Data Certification Statement in the Report Binder shall be utilized and include the following:<br><br>• Health Network name, certification month and year<br>• Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer)<br>• Signature date, job title, and Health Network department. | APL 17-005: Certification of Document and Data Submissions<br><br>DHCS Medi-Cal Contract, Exhibit E, Attachment 2<br><br>CalOptima Health Network Contract, Section 7.12 | Monthly:<br>25th of each month | X | | | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Health Network Newly Contracted Provider Training Report | Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.<br><br>The report includes the following:<br><br>• Program (Medi-Cal, OneCare, OneCare Connect)<br>• Provider name, NPI, and active status date<br>• Date the training started and date the training was completed<br>• Whether signed acknowledgment was received from provider<br>• Comments/explanation of missed deadline(s) | CalOptima Policy EE.1103: Provider Education and Training<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 7, Provisions 5<br>Attachment 9, Provision 12<br><br>APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities<br><br>Cal MediConnect 3-Way Contract, Section 2.9.11 | Quarterly:<br>January 25, April 25, July 25, October 25 | X | X | X | X | X | X |
| Primary Care Provider (PCP) Upload File | Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.<br><br>The report includes the following:<br><br>• Member site, ID, and suffix<br>• PCP effective date, ID, and suffix<br>• Health Network ID and suffix<br>• Medical center ID and suffix<br>• Staff Vs center indicator<br>• Pay to Tax ID number (Health Network Tax ID)<br>• Pay to Tax ID suffix<br>• PCP reason code<br>• Name of individual provider, group, or clinic | CalOptima Health Network Contract, Sections:<br>3.12<br>7.1<br>7.11<br><br>CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4<br><br>CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP) | Bi-monthly:<br>10th and 25th of every month | X | | | X | | |
| DHCS Supplemental Data – Kaiser | Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.<br><br>The report includes the following:<br><br>• Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI).<br>• Member name and CIN<br>• Health Care Plan (HCP) code<br>• Month of service<br>• Member enrollment status indicator<br>• Services rendered<br>• Diagnosis date<br>• Delivery date<br>• Number of weeks for Hep-C multiplier<br>• Indicator for correction record<br>• Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret | DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16<br><br>Technical Guidance: Consolidated Supplemental Upload Process | Monthly:<br>15th of every month | X | | | | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Number of encounters | | | | | | | | |
| Vision Service Plan (VSP) Provider Roster | VSP shall submit monthly report of VSP providers for the print and online provider directories.<br><br>The report includes the following:<br><br>• Practice name, doctor name, and provider specialty<br>• Provider address, phone number, and county name<br>• Non-English languages spoken by provider and/or clinical staff<br>• Provider NPI, license number and type, special experience, and gender<br>• Accepting new patients, and ages seen<br>• Hours of operation from Monday through Sunday | CalOptima VSP Contract, Sections:<br>1.17<br>7.1 | Monthly:<br>15th of every month | X | | | | | X |
| Health Education Calendar - Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes.<br><br>The report shall include, at a minimum:<br><br>• Class or program name<br>• Location<br>• Date and time | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |
| Health Education Individual Encounters-Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs.<br><br>The report shall include, at a minimum:<br><br>• Class or program<br>• Number of members in attendance | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |
| Health Education Other Encounters - Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs.<br><br>The report shall include, at a minimum:<br><br>• Class or program<br>• Number of members in attendance | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Perinatal Support Services (PSS) Encounters - Kaiser | Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.<br><br>The data include the following:<br><br>• Member CIN<br>• Member DOB<br>• Estimated Delivery Date<br>• Participating in CPSP (Y/N)<br>• Date CPSP Initiated | CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7 | Monthly:<br>15th of every month | X | | | | X | |
| Access and Availability Report - Kaiser | Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards.<br><br>The report includes the following:<br><br>• Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access<br>• Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access<br>• Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services<br>• Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network<br>• Documenting at least one intervention and measure effectiveness of interventions (if applicable) | DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation<br><br>DHCS Proposed Annual Network Certification Policy Changes<br><br>NCQA Standards, Network Management:<br>Net 1B – 1D<br>Net 2A – 2C<br>Net 3A – 3C<br><br>CalOptima Policy GG.1600: Access and Availability Standards<br><br>CalOptima Policy MA.7007: Access and Availability<br><br>Title 28, CCR, Sections:<br>1300.67.2<br>1300.67.2.1<br>1300.67.2.2<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 6<br>Attachment 9<br><br>Cal MediConnect 3-Way Contract, Section 2<br><br>Title 42, CFR, Section 438.206-207 | Annually:<br>February 15 | X | | | | X | |
| Quality Improvement (QI) Evaluation | Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.<br><br>The evaluation includes the following: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4 | Annually:<br>February 15 | X | | | | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| (Previous Year) – Kaiser, VSP | • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service<br>• Trending of measures to assess performance in the quality and safety of clinical care and quality of service<br>• Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices | CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | | | | | | | |
| QI Program – Kaiser, VSP | Kaiser shall develop an annual QI program description and submit to CalOptima for review.<br><br>The program includes description of the following:<br><br>• The QI program structure<br>• The behavioral healthcare aspects of the program<br>• Involvement of a designated physician in the QI program<br>• Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program<br>• Oversight of QI functions of the organization by the QI Committee<br>• Objectives for serving a culturally and linguistically diverse membership | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Annually: February 15 | X | | | | X | X |
| QI Work Plan – Kaiser, VSP | Kaiser shall report progress towards quality improvement program goals semi-annually.<br><br>The QI work plan includes the following:<br><br>• Yearly planned QI activities and objectives<br>• Timeframe for each activity's completion<br>• Staff members responsible for each activity<br>• Monitoring of previously identified issues<br>• Evaluation of the QI program | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Semi-Annually: February 15 and August 15 | X | | | | X | X |
| QI Work Plan Current Year (Initial) – Kaiser, VSP | Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.<br><br>The work plan includes the following:<br><br>• Yearly planned QI activities and objectives<br>• Timeframe for each activity's completion<br>• Staff members responsible for each activity<br>• Monitoring of previously identified issues<br>• Evaluation of the QI program | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Annually; February 15 (for new year) | X | | | | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Quarterly QI Committee Minutes – Kaiser ~~Report of Findings and Actions Taken as a Result of QI Activities – Kaiser, VSP~~ | Kaiser shall present for CalOptima review the QI Committee Meeting Minutes from the previous quarter. Presentation may be in person or by webinar.~~Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.~~<br><br>The report includes the following, at a minimum:<br><br>• Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions)<br>• An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB) | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Quarterly | X | | | | X | ~~X~~ |
| Authorization Utilization Report | Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable).<br><br>The report includes the following:<br><br>• Member name, Client Identification Number (CIN), and date of birth<br>• Health Network name or number, and PCP name<br>• Authorization tracking/case number<br>• Authorization request date, approved date, effective date, and expiration date<br>• Services requested (CPT code and description)<br>• Diagnosis (ICD and description)<br>• Services approved to (name of provider or health delivery organization)<br>• Specialty of provider who is authorized for services<br>• Whether claim was submitted and date claim was paid | DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1<br><br>CalOptima Health Network Contract, Sections:<br>7.1<br>7.11<br><br>CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements<br><br>CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting | Quarterly:<br>Q3 2020 - February 15, 2021<br>Q4 2020 - May 15, 2021<br>Q1 2021 - August 15, 2021<br>Q2 2021 - November 15, 2021~~Q3 2019 - February 15, 2020~~<br>~~Q4 2019 - May 15, 2020~~<br>~~Q1 2020 - August 15, 2020~~<br>~~Q2 2020 - November 15, 2020~~ | X | | | X | X | |
| Dental Anesthesia Report | Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD).<br><br>The report includes the following:<br><br>• Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD<br>• Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons<br>• Reasons for the other denials for dental general anesthesia<br>• Dental general anesthesia reporting comments | APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage<br><br>CalOptima Health Network Contract, Sections:<br>7.1<br>7.11<br><br>CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements<br><br>CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting | Quarterly:<br>15th of the month after the end of the quarter | X | | | X | X | |
| UM Evaluation (Previous Year) | Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.<br><br>The UM Evaluation includes the following: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5 | Annually:<br>February 15 | X | X | X | X | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include:<br>• Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | NCQA Standards, Utilization Management, UM1 | | | | | | | |
| UM Program | Health Networks shall develop a UM program description and submit to CalOptima for review.<br><br>The UM Program includes a description of the following:<br><br>• Written description of the program structure<br>• Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program<br>• Behavioral healthcare aspects of the program<br>•The program scope and process used to determine benefit coverage and medical necessity<br>• UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities<br>• Information sources used to determine benefit coverage and medical necessity<br>• The Health Network annually evaluates and updates the UM program, as necessary | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5<br><br>NCQA Standards, Utilization Management, UM1 | Annually:<br>February 15 | X | X | X | X | X | |
| UM Work Plan (ICE) | Health Networks shall report progress towards UM program goals semi-annually.<br><br>The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include:<br><br>• Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM Work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5 | Semi-Annually:<br>February 15 and<br>August 15 | X | X | X | X | X | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| UM Work Plan Current Year (Initial) | Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.<br><br>The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include:<br><br>• Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/Under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5 | Annually:<br>February 15 (for new year) | X | X | X | X | X | |
| Out-of-Network (OON) Requests | Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.<br><br>The report includes the following:<br><br>• Health Network name, and reporting quarter and year<br>• Date of OON referral request, and referral authorization number<br>• Member name and CIN<br>• Specialist name, NPI, address, and specialty type<br>• Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network)<br>• Resolution status (approved, denied, pending) | APL 20-003: Network Certification Requirements, Network Certification Non-Compliance<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 9 | Quarterly:<br>January 25, April 25, July 25, October 25 | X | | | X | X | |
| Kaiser WCM Claim Detail | Kaiser shall submit monthly report of WCM claims payment information.<br><br>The report includes the following:<br>• CalOptima claim number and line, Kaiser claim number)<br>• Provider name, NPI and tax identification number<br>• Member CIN and name<br>• Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units.<br>• Kaiser amount billed and paid<br>• CalOptima amount<br>• Claim remittance code and description<br>• Report month and fiscal year<br>• Check date, number and amount | CalOptima Health Network Contract, Section 9.11<br><br>CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks | Monthly:<br>15th of every month | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Preclusion List Report for Member Notifications Only | Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks.<br><br>The report includes the following:<br><br>• Line of business (OneCare, OneCare Connect)<br>• Member name, CIN, date of birth, address, and language<br>• Precluded provider name and NPI<br>• Service type (health care services, health care items, or prescriptions)<br>• Preclusion list impacted membership attestation | HPMS Memo, 11/2/18, Preclusion List Requirements<br><br>Final Rule, Vol. 83, No. 73, April 2018 | Monthly:<br>10th of every month | X | X | X | X | X | X |
| Directed Payments File | Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.<br><br>The report includes the following:<br><br>• Claim line ID<br>• Health Network ID, claim number, and claim line number<br>• Member name, CIN, and date of service<br>• Clean claim or encounter received date<br>• Whether an adjustment and previous claim number<br>• Rendering provider name and NPI<br>• Billing provider name, NPI, and Tax ID<br>• Billed CPT/HCPCS code and modifier (if applicable)<br>• Provider billed amount, and whether contracted provider claim<br>• Claim paid amount and adjustment code (if applicable)<br>• Whether fee-for-service or capitated claim<br>• Directed payment amount and paid date, and check or EFT transaction number<br>• Reimbursement disposition (reserved for CalOptima use)<br>• Optional fields (for unique identifiers/specific to HN to help with reconciliation) | APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services<br><br>APL 19-015: Proposition 56 Directed Payments for Physician Services<br><br>APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services<br><br>APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services<br><br>APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations<br><br>APL 20-013: Proposition 56 Directed Payments for Family Planning Services<br><br>CalOptima Policy FF.2011: Directed Payments<br><br>CalOptima Health Network Contract, Attachment E-2 | Monthly:<br>10th of every month | X | | | X | X | |
| Kaiser WCM Rx Detail | Kaiser shall submit monthly report of WCM Rx payment information.<br><br>The report includes the following:<br><br>• Member CIN, date of birth, and MRN (assigned by Kaiser)<br>• Pharmacy NPI and fill date<br>• Prescriber NPI and prescription number<br>• Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag<br>• Drug name, quantity, days of supply, and amount paid<br>• Eligibility for Medi-Cal and CCS<br>• Duplicate record indicator and load date | CalOptima Health Network Contract, Section 9.11<br><br>CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks | Monthly:<br>15th of every month | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | | | | | | | | | |
| FDR Compliance Attestation | The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation.<br><br>The report includes the following:<br>• Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE)<br>• Organization name<br>• Applicability of General and HIPAA Compliance and FWA Training<br>• Applicability of Compliance Plan and Code of Conduct Requirements<br>• Authorized Signature, Name, Email and Date<br>• Organization Name | CalOptima Policy: HH.2023: Compliance Training<br><br>CalOptima Health Network Contract, Sections:<br>3.26<br>3.27<br><br>Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual;<br><br>8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS;<br><br>9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States;<br><br>7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States. | Initial upon contracting;<br>Annually thereafter | X | X | X | X | X | X |
| Claims Timeliness Report | Health Networks shall submit a monthly claims payment performance (timeliness) report.<br><br>The report includes the following:<br>• Health Network name, management company name and report preparer name, title and email.<br>• The reporting year, quarter and month(s).<br>• The number of paid, contested and member-denied claims.<br>• The number of claims paid within timeliness requirements.<br>• The number of unprocessed claims on hand.<br>• The total number of all claims received<br>• The number of emergency room (ER) claims paid, contested and denied.<br>• The number of ER claims paid timely.<br>• Certification signed by principal officer, including name, title, phone and email. | CalOptima Health Network Contract, Section 2.7.8<br><br>Kaiser HMO Contract, Section 2.3.8<br><br>CalOptima VSP Contract, Section 3.8 | Monthly:<br>15th of every month<br><br>Quarterly:<br>January 30, April 30, July 30, October 30 | X | X | X | X | X | X |
| 274 Provider Directory – Kaiser | Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide.<br><br>The report includes the following:<br>• Provider and Group name, NPI, TIN, taxonomy and effective/term date(s).<br>• Site name, bed counts, membership min/max, demographics, language(s) spoken, schedule, ownership.<br>• Provider name, membership min/max, demographics, language(s) spoken, schedule, telehealth status. | CalOptima Policy: HH.2003 Health Network and Delegated Entity Reporting;<br><br>CalOptima Policy: EE.1101 Additions, Changes, and Terminations to Provider Information CalOptima Provider Directory and Web-based Directory;<br><br>DHCS Medi-Cal Contract: Exhibit A, Attachment 3; | Monthly:<br>2nd of every month | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | | NCQA Element MED14B: Pharmacy Directory Data;<br><br>NCQA Element MED14C: Behavioral Healthcare Directory Data;<br><br>NCQA Element MED14D: Long-Term Services and Supports Provider Directory Data | | | | | | | |
| Provider Termination Quarterly Report - Kaiser | Monitor Kaiser's adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice.<br><br>The report includes the following:<br>• Termination Date<br>• Providers Name<br>• Provider Type<br>• Did the Termination Result in One or More of the Annual Network Certification Components to No Longer be Compliant? (Y/N)<br>• Impacted County<br>• Date Member Notice was mailed<br>• Number of Members Impacted (As of Date Notice Received)<br>• Number of Members that were Reassigned Outside of the Time and Distance Standards<br>• Is an Accessibility Analysis or AAS Request Being Submitted with this Report?<br>• Enter the Number of Days' Notice the Provider gave the MCP<br>• Enter the Provider ID<br>• Enter the Provider NPI<br>• Enter the Provider Termination Reason<br>• Indicate if the Provider is CCS Paneled? (Y/N) | CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting;<br><br>NCQA Element MED1H: Notification of Termination of a Practitioner or Practice Group Standard | Quarterly:<br>10th of the month following the end of each quarter | X | | | | X | |
| UM Retrospective Appeal Universe | Monitor the Health Networks' handling of first level UM Provider Appeals.<br><br>The report includes the following:<br>• Member Name<br>• ID Number (CIN)<br>• LOB<br>• Request Type<br>• Date the Request was Received<br>• Time the request was received<br>• Was the AR requested as expedited?<br>• Was the AR processed under the expedited timeframe?<br>• Was a timeframe extension taken?<br>• Procedure Codes Requested<br>• Diagnosis Code(s), (ICD-10)<br>• Decision Date<br>• Decision Time<br>• Action (Approved, Modified, Denied) | CalOptima Health Network Contract Section 4.9.7: Provider Level 1 UM Appeals | Quarterly:<br>10th of the month following the end of each quarter | X | X | X | X | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS: Medi-Cal | LINE OF BUSINESS: OneCare | LINE OF BUSINESS: OneCare Connect | REPORT REQUIREMENT INDICATOR: Health Networks (Except Kaiser) | REPORT REQUIREMENT INDICATOR: Kaiser | REPORT REQUIREMENT INDICATOR: VSP |
|---|---|---|---|---|---|---|---|---|---|
| | • Authorization Number<br>• Provider Notification Date<br>• Provider Notification Time<br>• Provider Written Notification Date<br>• Provider Written Notification Time<br>• Member Written Notification Date<br>• Member Written Notification Time<br>• Threshold Language<br>• Was an Appeal Received (Y/N)?<br>• Date Appeal was Received<br>• Date of Appeal Decision<br>• Decision (Approved, Modified, Denied)<br>• Provider Written Appeal Notification Date | | | | | | | | |
| Semi-Annual Site Visit Report - Kaiser | The report captures sites that received an Initial or Periodic FSR/MRR.<br><br>The report includes the following:<br>• Site ID<br>• Site Address<br>• Suite No.<br>• City<br>• State<br>• Zip<br>• County<br>• Plan#<br>• Health Plan Name<br>• Site Specific Certification #1-#4<br>• Provider Phone #<br>• Clinic Type<br>• Reviewer ID | DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review<br><br>NCQA Elements MED 3B and MED 5B | Semi-Annually: February 15 and August 15 | X | | | | X | |
| Kaiser Pharmacy Monitoring Report | Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates.<br><br>The report includes the following:<br>• Samples of pharmacy information as displayed on Kaiser's website and/or member portal.<br>• Samples showing updates to pharmacy information displayed on Kaiser's website and/or member portal. | NCQA Elements ME 5A, ME 5B, ME 5C, ME 5D | Semi-Annually: April 1 and October 1 | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Annual Audit | Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements.<br><br>The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable:<br><br>• Access & Availability<br>• Care Delivery Model<br>• Claims<br>• Compliance<br>• Credentialing<br>• Cultural & Linguistics<br>• Customer Service<br>• Encounters<br>• Information Systems<br>• Mailroom Process<br>• Marketing<br>• Medi-Cal Addendum<br>• Member Grievances & Appeals<br>• Network Management<br>• Provider Network Contracting<br>• Provider Relations<br>• Quality Improvement<br>• Sub-Contractual<br>• Translation Services<br>• Utilization Management<br>• Whole Child Model | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>APL 17-004: Sub-Contractual Relationships and Delegation | Annually:<br>per process | X | X | X | X | X | X |
| Claims XML Universe | Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0.<br><br>The report includes the following:<br><br>• Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process)<br>• CalOptima Line of Business (LOB)<br>• Claim number, form type, bill type in UB04, admission code, place of service name and code<br>• Authorization number<br>• Was claim adjusted and clean<br>• Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy HH.2015: Health Network Claims Processing<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>5.1.9<br>5.1.9.2<br>5.1.10 | Monthly:<br>2nd of every month | X | X | X | X | X | X |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Beneficiary name, Client Identification Number (CIN), threshold language<br>• Requestor type, receipt date and time<br>• Date and time of additional information requested (AIR)<br>• Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status<br>• Rendering provider name, NPI, Tax ID, specialty, contracted status<br>• Medical necessity denials<br>• Date and time claim received, loaded in system, decision made, claim redirected<br>• Payment information method, number, print date and time, transfer date and time<br>• Mail date and time of written notification to member and provider<br>• Decision maker name, title and credentials<br>• International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting<br>• Date of service<br>• Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount<br>• Paid revenue code, description, and CPT/HCPC<br>• Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description<br>• Paid reason for CPT/HCPC change<br>• Decision type and decision denial reason | DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4<br><br>Medicare Managed Care Manual Chapter 11, Section 110.2<br><br>Title 42, Code of Federal Regulations (CFR), Sections:<br>422.520 (a)<br>447.45 (d) | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Claims Universe Case Files | Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br>Paid Claims:<br>• Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date)<br>• Authorization, if applicable<br>• Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable<br>• Proof of check clearing (bank statements or copy of cancelled check)<br><br>Denied/Contested Claims:<br>• Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date)<br>• Eligibility print screen if contested/denied for eligibility<br>• System notes pertaining to claim<br>• If applicable, denial letters for member liability denials and any supporting documents used to determine the denial<br>• RA/EOB with interest, if applicable<br><br>Adjustments:<br>• Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt)<br>• Original RA/EOB showing payment or denial<br>• Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.)<br>• Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.)<br>• All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development<br>• RA/EOB with applicable interest<br>• Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy HH.2015: Health Network Claims Processing<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>5.1.9<br>5.1.9.2<br>5.1.10<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.520 (a)<br>447.45 (d) | Monthly:<br>10th of every month | X | X | X | X | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Credentialing Monthly Universe | Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.<br><br>The report includes the following:<br><br>• Health Network name, reporting month and year<br>• Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report<br>• Data ID (IC/RC/TM)<br>• CalOptima program (Medi-Cal, OneCare, OneCare Connect)<br>• Individual practitioner name, license number and type<br>• Contract type and primary contracted specialty<br>• Current and previous credentialing decision dates<br>• Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date<br>• Current facility site review date<br>• Current, signed attestation date<br>• Termination date and reasons for termination<br>• Date Change Termination (CT) form was submitted | NCQA Standards, Credentialing/Recredentialing:<br>CR3<br>CR4<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment<br><br>CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities<br><br>CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.10.5<br>2.16.3.3<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions:<br>6<br>12<br><br>Medicare Managed Care Manual:<br>Chapter 6, Section 60.3<br>Chapter 11, Section 110.2 | <u>Health Networks and Kaiser</u><br>Monthly:<br>2nd of every month<br><br><u>VSP</u><br>Quarterly:<br>January 10, April 10, July 10, October 10 | X | X | X | X | X | X |
| Credentialing Universe Monthly Case Files | Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br><u>Initial Credentialing</u><br>• Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter<br>• File checklist<br>• Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization)<br>• License verification<br>• Copy of DEA certificate or verification of DEA registration<br>• Work history, and education and training verification<br>• Board certification verification, as applicable | NCQA Standards, Credentialing/Recredentialing:<br>CR3<br>CR4<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment<br><br>CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities | Monthly:<br>10th of every month | X | X | X | X | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage<br>• Copy of current malpractice/professional liability policy<br>• National Practitioner Data Bank query<br>• State sanctions or restriction on licensure verification<br>• Medicare/Medicaid sanction verification<br>• Office of Inspector General (OIG) review<br>• System for Award Management (SAM) review<br>• Medi-Cal Suspended and Ineligible review<br>• Medicare opt-out review<br>• CMS Preclusion List review<br>• Current Facility Site Review, if applicable<br>• Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners)<br>• Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners<br><br><u>Recredentialing</u><br>• Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter<br>• Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter<br>• File checklist<br>• Performance monitoring documentation<br>• Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization)<br>• License verification<br>• Copy of DEA certificate or verification of DEA registration<br>• Board certification verification, as applicable<br>• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage<br>• Copy of current malpractice/professional liability policy<br>• National Practitioner Data Bank query<br>• State sanctions or restriction on licensure verification<br>• Medicare/Medicaid sanction verification<br>• Office of Inspector General (OIG) review<br>• System for Award Management (SAM) review<br>• Medi-Cal Suspended and Ineligible review<br>• Medicare opt-out review<br>• CMS Preclusion List review<br>• Current Facility Site Review, if applicable<br>• Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners)<br>• Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners | CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners<br><br>CalOptima Policy GG.1619: Delegation Oversight<br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.10.5<br>2.16.3.3<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions:<br>6<br>12<br><br>Medicare Managed Care Manual:<br>Chapter 6, Section 60.3<br>Chapter 11, Section 110.2 | | | | | | | |
| Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect) | Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.<br><br>The report includes the following:<br><br>• Member identifier, medical record number, and facility service type<br>• Date of termination request/notice and date of actual termination | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.9<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2 | Monthly:<br>2nd of every month | | X | X | X | | |

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS: Medi-Cal | LINE OF BUSINESS: OneCare | LINE OF BUSINESS: OneCare Connect | REPORT REQUIREMENT INDICATOR: Health Networks (Except Kaiser) | REPORT REQUIREMENT INDICATOR: Kaiser | REPORT REQUIREMENT INDICATOR: VSP |
|---|---|---|---|---|---|---|---|---|---|
| | • Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt<br>• Date of discharge | Title 42, CFR, Sections:<br>405.1200 (b)(1) & (2)<br>422.624 (b)(1) and (2) | | | | | | | |
| NOMNC Files (OneCare & OneCare Connect) | Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>NOMNC files include the following:<br><br>• Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services<br>• Date of termination request<br>• Date of actual termination (including date, time and name of provider making the request)<br>• Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services)<br>• Member/member's representative notified of appeal rights<br>• Date of termination request/notification signed by the member/member's representative<br>• Copy of signed NONMC letter<br>• Date of discharge<br><br>If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required:<br>• Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice)<br>• Proof of letter mailed on same date of call made to member's representative<br>• If provider is unable to reach member's representative by phone, provide proof of the following:<br>o Certified mail receipt with return receipt request<br>o Date someone at the representative's address signs or refuses to sign the letter<br>o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file | CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.9<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>405.1200 (b)(1) & (2)<br>422.624 (b)(1) and (2) | Monthly:<br>10th of every month | | X | X | X | | |
| Provider Dispute Resolution (PDR) XML Universe | Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0.<br><br>The report includes the following:<br><br>• Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect)<br>• Unique ID number used to track authorization request<br>• Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR<br>• Check number used to pay overturned PDR request, and date and time check was mailed<br>• Date and time the written notification was provided to the provider<br>• Name and title of the decision maker of the PDR request | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 | Monthly:<br>2nd of every month | X | X | X | X | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received<br>• Billing provider's name, NPI number, tax ID number, specialty, and whether contracted<br>• Claim number of the original claim being appealed, and decision date and time of the original claim being appealed<br>• Member's name, CIN, and preferred language<br>• ICD type and diagnosis code<br>• Start date and end date of services rendered<br>• Billed revenue code, CPT/HCPC code, and modifier<br>• Billed units and billed amount<br>• Paid amount (excluding interest), withhold amount, and paid interest amount<br>• Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason<br>• Adjustment code and description | Health and Safety Code (HSC), Section 1367:<br>(h)(1)<br>(2)<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 28, California Code of Regulations (CCR), Section 1300.71.38:<br>(b)<br>(c)<br>(d) | | | | | | | |
| PDR Universe Case Files | Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>Case files include the following:<br><br>• Copy of original claim, and received date (if electronic claim, a print screen showing received date)<br>• Original RA/EOB showing payment or denial<br>• Provider dispute request along with pertinent documents submitted, and date received<br>• All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development<br>• Acknowledgement letter, and resolution letter sent to provider<br>• EOB showing payment with applicable interest, if original decision of payment denial is overturned<br>• Proof of check clearing (bank statements or copy of cancelled check) if payment is issued | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2<br><br>HSC, Section 1367:<br>(h)(1)<br>(2)<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 28, CCR, Section 1300.71.38:<br>(b)<br>(c)<br>(d) | Monthly:<br>10th of every month | X | X | X | X | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Provider Directory Universe Case Files | Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results.<br><br>The Provider Directory file review is based on a signed and dated provider attestation that includes the following:<br>• Provider name, California license number, and gender<br>• Address (office locations), office days and hours, day phone number, and after-hours phone number<br>• Administrative email address, or office fax number (if no administrative email available)<br>• Languages spoken by provider and staff<br>• Primary specialty (i.e. dermatology, internal medicate, etc.)<br>• Accepting new patients (i.e., open or closed panel), and age restrictions<br>• Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital)<br>• Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP)<br>• Programs (i.e. Medi-Cal, OneCare, OneCare Connect)<br>• Provider type in this network (i.e. Primary Care Provider, Specialist)<br>• Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number<br>• Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment."<br>• Designated space for printed name, signature and date for the provider office manager or equivalent staff | APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Health Network Contract, Section 7.10<br><br>CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.17.5.11<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4<br><br>HSC, Section 1367.27<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Section 438.10 (h) | Annually, per request | X | X | X | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Utilization Management (UM) XML Universe | Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1.<br><br>The report includes the following:<br><br>• Version, as of date, entry identification (ID), and line of business (LOB) for this authorization<br>• ID number used to track the authorization request (AR), and type of AR<br>• Whether authorization is for Part B or physician administered drugs and/or administration<br>• Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist<br>• Method AR was received, and authorization number related to AR<br>• CMS place of service code and name<br>• Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network)<br>• Member name, CIN, and preferred language<br>• AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator)<br>• Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB)<br>• Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received<br>• Requesting provider/group/facility name, NPI, tax ID number, and whether contracted<br>• Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted<br>• Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted<br>• Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit)<br>• Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date<br>• Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe<br>• If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe<br>• If a request to expedite was made after the original request, identify requestor of subsequent request to expedite<br>• Whether a timeframe extension was taken<br>• Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member<br>• The method used to initially notify the requesting provider of the decision of authorization request<br>• Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream<br>• Whether the review was completed by a physician or other appropriate health care professional<br>• Name, job title, and credentials of the decision maker of the AR<br>• Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description<br>• Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units<br>• Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units<br>• Determination of the requested service<br>• Reason for the denial or modification of the requested service | NCQA Standards, Utilization Management, UM5<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1541: Utilization Management Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.6.3<br>2.11.7<br>2.11.9<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions:<br>2<br>3<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.572(a) & (b)<br>422.568 (b)(1)<br><br>Medicare Part C Reporting Requirements, Section VI | Monthly:<br>2nd of every month | X | X | X | X | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| UM Universe Case Files | Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.<br><br>UM case files include the following documentation:<br><br>Medi-Cal<br>• Approval file checklist includes all medical records attached to file and transaction log<br>• Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log<br>• Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log<br><br>OneCare<br>• Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available<br>• Denial file checklist includes denial letter, all medical records attached to the file and transaction log<br><br>OneCare Connect<br>• Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available<br>• Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available | NCQA Standards, Utilization Management, UM5<br><br>APL 17-004: Sub-Contractual Relationships and Delegation<br><br>CalOptima Policy GG.1541: Utilization Management Delegation<br><br>CalOptima Policy GG.1619: Delegation Oversight<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.11.6.3<br>2.11.7<br>2.11.9<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions:<br>2<br>3<br><br>Medicare Managed Care Manual, Chapter 11, Section 110.2<br><br>Title 42, CFR, Sections:<br>422.572(a) & (b)<br>422.568 (b)(1) | Monthly:<br>10th of every month | X | X | X | X | X | |
| Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser | Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.<br><br>The report includes the following:<br><br>• Plan code, name, county and reporting period<br>• Number of CDE referrals<br>• Number of referrals determined appropriate for CDE<br>• Number of CDE completed<br>• Number of CDE appointments scheduled within and outside timely access<br>• Number of CDE not scheduled but offered appointment<br>• Number of CDE with appointment not yet scheduled<br>• Comments | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 | Monthly:<br>15th of each month | X | | | | X | |
| Mental Health Grievances and Appeals (Medi-Cal) - Kaiser | Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data.<br><br>The report includes the following: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 | Quarterly:<br>January 20, April 20, July 20, October 20 | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Plan code, name, county, reporting quarter and total number of members<br>• Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code<br>• Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description<br>• Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period<br>• Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for<br>• Average number of days taken to deny requests<br>• Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description<br>• Number of COC requests in process and comments | | | | | | | | |
| Case Management Log | Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services.<br><br>The report includes the following:<br><br>• Member name, CIN, date of birth, and program<br>• Diagnosis and ICD-10 code (qualifying member for case management)<br>• Referral/data source to case management, date opened, and date closed<br>• Case management level, status change reason, and complex case trigger<br>• Additional programs to which member has been referred<br>• Special program to which member is enrolled, or any special needs of member | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 1<br>Attachment 11, Provision 2<br><br>APL 17-004: Subcontractual Relationships and Delegation<br><br>NCQA Standards, Population Health Management:<br>PHM5<br>PHM7 | Monthly:<br>15th of every month | X | | X | X | X | |
| Continuity of Care (Whole-Child Model) | Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.<br><br>The report includes the following:<br>• Requestor type, date of request, and request type<br>• Member name and CIN<br>• COC begin processing date and date of decision<br>• COC completion date (including member notification) and COC expiration date<br>• Requested provider NPI and provider type<br>• Decision outcome, denial reason, and explanation of other reasons<br>• Next steps taken for incomplete requests | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 10 | Weekly:<br>Every Tuesday by 10 am for the prior week's activity | X | | | X | X | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Enhanced Monitoring Report (WCM) | Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.<br><br>The report includes the following:<br><br>Health Networks (including Kaiser):<br>• Describe any challenges with care coordination and Health Network's role in overcoming barriers<br>• Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions<br>• For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes<br><br>Kaiser Only:<br>• Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP<br>• Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11, Provision 10 | Quarterly:<br>5th day after the end of the quarter | X | | | X | X | |
| Health Homes Program (HHP) Enrollment and Disenrollment Report | Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.<br><br>The report includes the following:<br><br>• Member name, CIN, and date of birth<br>• Whether HHP enrolled member was externally referred<br>• HHP disenrollment date and reason<br>• Whether member is homeless/at risk for homelessness, or received housing services during reporting period<br>• Whether member was homeless at any point during enrollment in HHP<br>• Whether member is no longer homeless as of the last day of reporting period<br>• File create date | DHCS HHP Program Guide<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |
| HHP Finalized Engagement List (FEL) Return File | Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.<br><br>The Health Network response file includes the following:<br><br>• Excluded because not eligible-well managed: Y/N<br>• Excluded because declined to participate: Y/N<br>• Excluded because of unsuccessful engagement: Y/N<br>• Excluded because of duplicative program: Y/N<br>• Excluded because of unsafe behavior or environment: Y/N<br>• Excluded because not enrolled in Medi-Cal at MCP: Y/N<br>• Enrollment date (if applicable) | DHCS HHP Program Guide<br><br>CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| HHP Services | Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.<br><br>The report includes the following:<br>• Claim line ID<br>• Health Network ID, claim number, claim line number<br>• Member name and CIN<br>• Date of service and service provided<br>• Claim or encounter received date<br>• Whether an adjustment, and previous claim number<br>• Rendering provider name and NPI<br>• Billing provider name, NPI, and Tax ID<br>• Billed CPT code and modifier, and primary diagnosis<br>• Units billed and provider billed amount<br>• Paid amount, and adjustment code<br>• Fee-for-service or capitated claim<br>• Check or EFT transaction number<br>• Optional user defined fields | DHCS HHP Program Guide<br><br>CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks<br><br>CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management<br><br>CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility | Monthly:<br>10th of every month | X | | | X | X | |
| Implementation Audit (OneCare Connect) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>DPL 15-001: ICP and ICT Requirements, Section A. Care Plans<br><br>Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections:<br>CA1.5<br>CA1.6<br><br>CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements | Ongoing, per process | | | X | X | | |
| Implementation Audit (OneCare) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Medicare Managed Care Manual, Chapter 5 | Ongoing, per process | | X | | X | | |

For 20210506 BOD Review Only

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Implementation Audit (Seniors and Persons with Disabilities (SPD)) | Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.<br><br>The report includes the following:<br><br>• Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes<br>• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes<br>• Non-hospitalization key events: Case management notes | APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | X | |
| Organ Transplant – Kaiser | Kaiser shall submit monthly report of members engaged in the organ transplant process.<br><br>The report includes the following:<br><br>• Member name, CIN, and date of birth<br>• Transplant related diagnosis and transplant type<br>• DHCS-approved transplant center where member will be transplanted<br>• Date the Health Network notified CalOptima of member's potential transplant status<br>• Current transplant phase and the date the phase began<br>• Date member is listed for transplant at DHCS-approved transplant center<br>• Date member was last contacted regarding case management/coordination care issues<br>• Date the transplant case is closed and reason for case closure<br>• Case manager name<br>• Additional comments to clarify report | APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions<br><br>Cal MediConnect 3-Way Contract, Section 2.2.4 | Monthly:<br>15th of every month | X | | | | X | |
| Annual Redetermination Files | Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.<br><br>The report includes the following:<br><br>• Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination.<br>• WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date. | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Section 6<br>Attachment 11, Section 10 | Ongoing, per process | X | | | X | X | |
| Individual Care Plan/Health Action Plan (ICP/HAP) bundle | Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.<br><br>The report includes the following:<br><br>• Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills.<br>• Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals. | Medi-Cal Health Homes Program Guide<br><br>APL 18-012: Health Homes Program Requirements | Ongoing, per process | X | | | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Clinical assessments/case management notes | | | | | | | | |
| Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA 1.1 - CA 1.5<br><br>OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>Medicare Managed Care Manual, Chapter 5, Sections:<br>20.2.1<br>2.C and D<br><br>DPL 15-001: ICP and ICT Requirements | Ongoing, per process | | | X | X | | |
| Interdisciplinary Care Team (ICT) Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | X | |
| ICT Bundle (OneCare) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Medicare Managed Care Manual, Chapter 5 | Ongoing, per process | | X | | X | | |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Long Term Care (LTC) ICP Bundle (OneCare Connect) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Final ICP that includes assessments, interventions, and goals set by the facility<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.2.4<br>2.5<br>2.8<br><br>DPL 15-001: ICP and ICT Requirements<br><br>CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2 | Ongoing, per process | | | X | X | | |
| Pediatric ICT Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.<br><br>The report includes the following:<br><br>• ICT notes/minutes, participants invited according to member's needs, and ICT attendees<br>• Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Copy of Care Planning Letter sent to Member with date mailed and preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports | Ongoing, per process | X | | | X | X | |
| Model of Care (MOC) SPD Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed)<br><br>Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM. | DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 | Monthly:<br>6th of every month | X | | | X | | |
| MOC Tracking Log (OneCare Connect) | Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number | Cal MediConnect 3-Way Contract, Sections:<br>2.5.2.7<br>2.5.2.7.1 | Monthly:<br>6th of every month | | | X | X | | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Care Management Level (CML)<br>• Reason for change in CML (if changed) | | | | | | | | |
| MOC Tracking Log (OneCare) | Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed) | Title 42, CFR, Section 422.101(f) | Monthly:<br>6th of every month | | X | | X | | |
| MOC WCM Tracking Log (Medi-Cal) | Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Member name and CIN<br>• PCC number<br>• Care Management Level (CML)<br>• Reason for change in CML (if changed)<br><br>Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM. | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) | Monthly:<br>6th of every month | X | | | X | | |
| Network Staff Legend File | Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding.<br><br>The report includes the following:<br><br>• Staff name, number (unique for each individual PCC or CC, phone number, and email<br>• For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments<br>• Model of Care (MOC) training received<br>• PCC training received and PCC staffing ratio met<br>• Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans<br>• Type of licensed staff or non-licensed CC staff<br>• Attestation from Manager/Director (name and title) to report information | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>Cal MediConnect 3-Way Contract, Sections:<br>2.5.2.7<br>2.5.2.7.1<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2<br><br>Title 42, CFR, Section 422.101(f) | Monthly:<br>6th of every month | X | X | X | X | | |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| WCM ICP Bundle (Medi-Cal) | Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion.<br><br>The report includes the following:<br><br>• ICT minutes, participants invited according to member's needs, and ICT attendees<br>• Case management notes summarizing discussions, follow up items, and parties responsible for follow up<br>• Documentation that the final ICP was distributed to invited participants, including the PCP and the member<br>• Member-friendly ICP in member's preferred language and format<br>• Copy of the final ICP signed by the PCP | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) | Ongoing, per process | X | | | X | X | |
| DHCS WCM Report - Kaiser | Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME<br>• Number of members identified as high risk and as low risk<br>• Number of WCM assessments completed to date for high risk members and for low risk members<br>• Number of WCM ICP completed to date for high risk members<br>• Number of WCM eligible members with diagnosis requiring a referral to SCC to date<br>• Number of WCM eligible members who have been seen by SCC to date<br>• Number of WCM member discharged from hospital to date<br>• Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date<br>• Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider<br>• Number of other WCM grievances and summary of such grievances<br>• Number of WCM appeals and summary of appeals | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4<br>Attachment 11, Provision 10 | Monthly:<br>15th of every month | X | | | | X | |
| Population Health Management (PHM) Program Description - Kaiser | Kaiser shall develop a PHM program description and submit to CalOptima for review.<br><br>The report includes the following:<br><br>• Quantitative results for relevant clinical, cost/utilization and experience measures<br>• Comparison of results with a benchmark | NCQA Standards, Population Health Management, PHM7 | Annually:<br>February 15th | X | | | | X | |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS WCM Report | Health Networks shall submit monthly report of WCM authorizations and care coordination.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME<br>• Number of members identified as high risk and as low risk<br>• Number of WCM assessments completed to date for high risk members and for low risk members<br>• Number of WCM ICP completed to date for high risk members<br>• Number of WCM eligible members with diagnosis requiring a referral to SCC to date<br>• Number of WCM eligible members who have been seen by SCC to date<br>• Number of WCM member discharged from hospital to date<br>• Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date | APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 11 Provision 10 | Monthly:<br>15th of every month | X | | | X | | |
| Claims Third Party Liability (TPL) (Medi-Cal) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.<br><br>The report includes the following:<br><br>• Member name, ID number, date of birth, and date of death (if applicable)<br>• Contractor's name (CalOptima)<br>• Provider name(s), and date of service<br>• Diagnosis code(s) and description of illness or injury<br>• Procedure codes(s) and description of services rendered<br>• Amount subcontractor or out-of-plan Provider billed, if applicable<br>• Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable<br>• Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable | CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL)<br><br>APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements<br><br>Cal MediConnect 3-Way Contract, Section 5.1.13.1<br><br>DHCS Medi-Cal Contract, Exhibit E, Attachment 2 | Monthly:<br>30th of every month | X | | | X | X | |
| Claims TPL (OneCare Connect) | Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.<br><br>The report includes the following:<br><br>• Member name, ID number, date of birth, and date of death (if applicable)<br>• Contractor's name (CalOptima)<br>• Provider name(s), and date of service<br>• Diagnosis code(s) and description of illness or injury<br>• Procedure code(s) and description of services rendered<br>• Amount subcontractor or out-of-plan provider billed, if applicable<br>• Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable<br>• Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable | CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability<br><br>Title 42, CFR, Sections:<br>405.378<br>411.24<br>422.108<br>423.462<br><br>CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights"<br><br>Cal MediConnect 3-Way Contract, Section 5.1.13 | Monthly:<br>30th of every month | | | X | X | | |

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|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS Post-Payment Recovery Report (Medi-Cal Only) | Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima.<br><br>The report includes the following:<br><br>• Project type (Third Part Liability "TPL")<br>• Name of Provider billing the claim, and provider tax ID number<br>• Claim type (What kind of claim was submitted, Facility, Professional, etc.)<br>• Member name, date of birth, ID number, and social security number<br>• Transaction control number (claim number)<br>• Begin date and end date of service<br>• Coordinated care organization bill amount (amount billed to TPL/Provider)<br>• Coordinated care organization paid amount (amount paid to the Provider)<br>• Bill date (date the claim was billed to the TPL)<br>• Remit amount (amount recovered from the TPL)<br>• Claim date of remit (date the claim was paid or denied by TPL)<br>• Check number related to remit amount<br>• Other insurance carrier name (name of the TPL that was billed)<br>• Claim status (disposition of the claim, paid, denied, open, etc.)<br>• Denial reason (the reason the claim was denied by the TPL) | APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage | Monthly:<br>3rd business day of every month | X | | | X | X | |
| Customer Service Call Log Universe | Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.<br><br>The report includes the following:<br><br>• File ID number, and line of business<br>• Member name and cardholder ID (assigned by HN to identify member)<br>• Date and time the call was received<br>• Category of the call and detailed description of the call<br>• Detailed description of the outcome/resolution of the call<br>• Date and time the call was resolved<br>• Customer Service Representative name who handled the call<br>• Member's language | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 13, Provision 2<br>Attachment 14, Provision 1<br>Attachment 14, Provision 2<br><br>Health and Safety Code (HSC), Section 1368(a)(1)<br><br>Title 28, CCR, Section 1300.68(a)<br><br>Cal MediConnect 3-Way Contract, Section 2.14<br><br>Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance<br><br>NCQA Element MED12D: Providing Information to Medicaid Members in the Practitioner Directory (Kaiser) | Quarterly:<br>January 7, April 7, July 7, October 7 | X | X | X | X | X | |

For 20210506 BOD Review Only



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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Health Network Dashboard | Health Networks shall submit report of call center statistics for monthly review.<br><br>The report includes the following:<br><br>• Total number of calls, average speed of answer, and average length of call in seconds<br>• Service levels (percentage of incoming calls answered within 30 seconds)<br>• Average speed to answer member services telephone calls with a live voice<br>• Abandonment rate (percentage of incoming calls disconnected)<br>• Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services)<br>• Number of calls by language | CalOptima Health Network Contract, Sections:<br>3.5<br>7.1<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3 | Monthly;<br>15th of every month | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Interpreter Services Utilization Report | Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.<br><br>The report includes the following:<br><br>• Requests for interpreter services by language (number of requests received, and number of requests fulfilled)<br>• Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff<br>• Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff<br>• Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted) | DHCS Medi-Cal Contract, Exhibit A, Attachment 6<br><br>Cal MediConnect 3-Way Contract, Section 2.11.1.2.2 | Quarterly:<br>January 30, April 30, July 30, October 30 | X | X | X | X | X | X |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | | REPORT REQUIREMENT INDICATOR | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| DHCS NMT/NEMT Report – Kaiser | Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, and reporting period<br>• Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above<br>• Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above<br>• Number of NMT denials<br>• Number of NMT and NEMT calls<br>• Number of NMT and NEMT grievances, and grievance reasons<br>• NMT/NEMT reporting comments | APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10<br><br>Welfare and Institutions Code, Section 14132 | Monthly:<br>27th of every month | X | | | | X | |
| Annual Audited Financial Statements | Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).<br><br>Audited financial statements include the following:<br><br>• Letters to management, and incurred but not reported (IBNR) documentation<br>• Consolidated corporate audited financial statements (if Health Network is part of a larger entity) | CalOptima Policy FF.3001: Financial Reporting | Annual submission due 120 days after organization's fiscal year ends | X | X | X | X | | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures | | | | | | | | |
| Incurred But Not Reported (IBNR) Documentation | Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report.<br><br>The IBNR documentation includes the following:<br><br>• Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims<br>• Supporting documentation for the IBNR calculation | CalOptima Policy FF.3001 Financial Reporting | Annual submission due 120 days after organization's fiscal year ends | X | X | X | X | | |
| Medical Loss Ratio (MLR) | Health Networks shall submit interim and final reports of the Health Network MLR.<br><br>MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic).<br><br>SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template. | CalOptima Policy FF.3001: Financial Reporting | Interim: January - June due August 15<br><br>Interim: January - December due February 15<br><br>Final: Annual submission of all 12 months due June 30 | X | | X | X | | |
| Risk Bearing Organization (RBO) Report | Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).<br><br>RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3. | CalOptima Policy FF.3001: Financial Reporting | Annual submission due 150 days after the fiscal year ends<br><br>Quarterly: February 15, May 15, August 15, November 15 | X | X | X | X | | |
| Total Business Reports | Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.<br><br>Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures. | CalOptima Policy FF.3001: Financial Reporting | Quarterly: February 15, May 15, August 15, November 15 | X | X | X | X | | |
| DHCS Quarterly Report - Kaiser | Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Year, quarter, plan code, member CIN<br>• Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other | CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3<br><br>APL 14-013: Grievance Report Template | Quarterly: January 23, April 23, July 23, October 23 | X | | | | X | |

# Timely and Appropriate Submission Grid – Supplemental Attachment

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • For the other category, grievance type(s) must be defined by HN<br>• Whether grievance was resolved (in favor of member or HN) or unresolved | APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments | | | | | | | |
| Grievances Volume Report - Kaiser | Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other<br>• Total of all grievance types | CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process<br><br>DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3 | Quarterly:<br>January 23, April 23, July 23, October 23 | X | | | | X | |
| Community-Based Adult Services (CBAS) Report - Kaiser | Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.<br><br>The report includes the following:<br><br>• Plan code, plan name, county, reporting quarter<br>• Number of requests for CBAS, and number of CBAS Providers<br>• Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services<br>• Average number of days between CBAS request and notice of eligibility<br>• Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center<br>• Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances<br>• Number of CBAS appeals approved, denied, and withdrawn<br>• Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS<br>• Number of CBAS complaint calls from member and from provider<br>• Explanations and summary of CBAS complaints<br>• CBAS reporting comments | CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6 | Quarterly:<br>January 23, April 23, July 23, October 23 | X | | | | X | |
| DHCS Data Certification Statement | Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.<br><br>The most current template Data Certification Statement in the Report Binder shall be utilized and include the following:<br><br>• Health Network name, certification month and year<br>• Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer)<br>• Signature date, job title, and Health Network department. | APL 17-005: Certification of Document and Data Submissions<br><br>DHCS Medi-Cal Contract, Exhibit E, Attachment 2<br><br>CalOptima Health Network Contract, Section 7.12 | Monthly:<br>25th of each month | X | | | X | X | X |

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Health Network Newly Contracted Provider Training Report | Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.<br><br>The report includes the following:<br><br>• Program (Medi-Cal, OneCare, OneCare Connect)<br>• Provider name, NPI, and active status date<br>• Date the training started and date the training was completed<br>• Whether signed acknowledgment was received from provider<br>• Comments/explanation of missed deadline(s) | CalOptima Policy EE.1103: Provider Education and Training<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 7, Provisions 5<br>Attachment 9, Provision 12<br><br>APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities<br><br>Cal MediConnect 3-Way Contract, Section 2.9.11 | Quarterly:<br>January 25, April 25, July 25, October 25 | X | X | X | X | X | X |
| Primary Care Provider (PCP) Upload File | Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.<br><br>The report includes the following:<br><br>• Member site, ID, and suffix<br>• PCP effective date, ID, and suffix<br>• Health Network ID and suffix<br>• Medical center ID and suffix<br>• Staff Vs center indicator<br>• Pay to Tax ID number (Health Network Tax ID)<br>• Pay to Tax ID suffix<br>• PCP reason code<br>• Name of individual provider, group, or clinic | CalOptima Health Network Contract, Sections:<br>3.12<br>7.1<br>7.11<br><br>CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4<br><br>CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP) | Bi-monthly:<br>10th and 25th of every month | X | | | X | | |
| DHCS Supplemental Data – Kaiser | Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep-C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.<br><br>The report includes the following:<br><br>• Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI).<br>• Member name and CIN<br>• Health Care Plan (HCP) code<br>• Month of service<br>• Member enrollment status indicator<br>• Services rendered<br>• Diagnosis date<br>• Delivery date<br>• Number of weeks for Hep-C multiplier<br>• Indicator for correction record<br>• Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret | DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16<br><br>Technical Guidance: Consolidated Supplemental Upload Process | Monthly:<br>15th of every month | X | | | | X | |

For 20210506 BOD Review Only

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Number of encounters | | | | | | | | |
| Vision Service Plan (VSP) Provider Roster | VSP shall submit monthly report of VSP providers for the print and online provider directories.<br><br>The report includes the following:<br><br>• Practice name, doctor name, and provider specialty<br>• Provider address, phone number, and county name<br>• Non-English languages spoken by provider and/or clinical staff<br>• Provider NPI, license number and type, special experience, and gender<br>• Accepting new patients, and ages seen<br>• Hours of operation from Monday through Sunday | CalOptima VSP Contract, Sections:<br>1.17<br>7.1 | Monthly:<br>15th of every month | X | | | | | X |
| Health Education Calendar - Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes.<br><br>The report shall include, at a minimum:<br><br>• Class or program name<br>• Location<br>• Date and time | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |
| Health Education Individual Encounters-Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs.<br><br>The report shall include, at a minimum:<br><br>• Class or program<br>• Number of members in attendance | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |
| Health Education Other Encounters - Kaiser | Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring.<br><br>Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs.<br><br>The report shall include, at a minimum:<br><br>• Class or program<br>• Number of members in attendance | CalOptima Policy GG.1201: Health Education Programs<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8 | Semi-Annually:<br>January 31 and July 31 | X | | | | X | |

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Perinatal Support Services (PSS) Encounters - Kaiser | Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.<br><br>The data include the following:<br><br>• Member CIN<br>• Member DOB<br>• Estimated Delivery Date<br>• Participating in CPSP (Y/N)<br>• Date CPSP Initiated | CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7 | Monthly:<br>15th of every month | X | | | | X | |
| Access and Availability Report - Kaiser | Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards.<br><br>The report includes the following:<br><br>• Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access<br>• Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access<br>• Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services<br>• Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network<br>• Documenting at least one intervention and measure effectiveness of interventions (if applicable) | DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation<br><br>DHCS Proposed Annual Network Certification Policy Changes<br><br>NCQA Standards, Network Management:<br>Net 1B – 1D<br>Net 2A – 2C<br>Net 3A – 3C<br><br>CalOptima Policy GG.1600: Access and Availability Standards<br><br>CalOptima Policy MA.7007: Access and Availability<br><br>Title 28, CCR, Sections:<br>1300.67.2<br>1300.67.2.1<br>1300.67.2.2<br><br>DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 6<br>Attachment 9<br><br>Cal MediConnect 3-Way Contract, Section 2<br><br>Title 42, CFR, Section 438.206-207 | Annually:<br>February 15 | X | | | | X | |
| Quality Improvement (QI) Evaluation | Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.<br><br>The evaluation includes the following: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4 | Annually:<br>February 15 | X | | | | X | X |

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# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| (Previous Year) – Kaiser, VSP | • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service<br>• Trending of measures to assess performance in the quality and safety of clinical care and quality of service<br>• Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices | CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | | | | | | | |
| QI Program – Kaiser, VSP | Kaiser shall develop an annual QI program description and submit to CalOptima for review.<br><br>The program includes description of the following:<br><br>• The QI program structure<br>• The behavioral healthcare aspects of the program<br>• Involvement of a designated physician in the QI program<br>• Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program<br>• Oversight of QI functions of the organization by the QI Committee<br>• Objectives for serving a culturally and linguistically diverse membership | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Annually: February 15 | X | | | | X | X |
| QI Work Plan – Kaiser, VSP | Kaiser shall report progress towards quality improvement program goals semi-annually.<br><br>The QI work plan includes the following:<br><br>• Yearly planned QI activities and objectives<br>• Timeframe for each activity's completion<br>• Staff members responsible for each activity<br>• Monitoring of previously identified issues<br>• Evaluation of the QI program | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Semi-Annually: February 15 and August 15 | X | | | | X | X |
| QI Work Plan Current Year (Initial) – Kaiser, VSP | Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.<br><br>The work plan includes the following:<br><br>• Yearly planned QI activities and objectives<br>• Timeframe for each activity's completion<br>• Staff members responsible for each activity<br>• Monitoring of previously identified issues<br>• Evaluation of the QI program | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Annually; February 15 (for new year) | X | | | | X | X |

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| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Quarterly QI Committee Minutes – Kaiser | Kaiser shall present for CalOptima review the QI Committee Meeting Minutes from the previous quarter. Presentation may be in person or by webinar.<br>The report includes the following, at a minimum:<br><br>• Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions)<br>• An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB) | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6<br><br>Kaiser HMO Contract, Section 6.4<br><br>CalOptima VSP Contract, Section 4.2<br><br>NCQA Standards, Quality Improvement, QI7 | Quarterly | X | | | | X | |
| Authorization Utilization Report | Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable).<br><br>The report includes the following:<br><br>• Member name, Client Identification Number (CIN), and date of birth<br>• Health Network name or number, and PCP name<br>• Authorization tracking/case number<br>• Authorization request date, approved date, effective date, and expiration date<br>• Services requested (CPT code and description)<br>• Diagnosis (ICD and description)<br>• Services approved to (name of provider or health delivery organization)<br>• Specialty of provider who is authorized for services<br>• Whether claim was submitted and date claim was paid | DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1<br><br>CalOptima Health Network Contract, Sections:<br>7.1<br>7.11<br><br>CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements<br><br>CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting | Quarterly:<br>Q3 2020 - February 15, 2021<br>Q4 2020 - May 15, 2021<br>Q1 2021 - August 15, 2021<br>Q2 2021 - November 15, 2021 | X | | | X | X | |
| Dental Anesthesia Report | Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD).<br><br>The report includes the following:<br><br>• Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD<br>• Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons<br>• Reasons for the other denials for dental general anesthesia<br>• Dental general anesthesia reporting comments | APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage<br><br>CalOptima Health Network Contract, Sections:<br>7.1<br>7.11<br><br>CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements<br><br>CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting | Quarterly:<br>15th of the month after the end of the quarter | X | | | X | X | |
| UM Evaluation (Previous Year) | Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.<br><br>The UM Evaluation includes the following:<br><br>• The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: | DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5<br><br>NCQA Standards, Utilization Management, UM1 | Annually:<br>February 15 | X | X | X | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | | | | | | | | |
| UM Program | Health Networks shall develop a UM program description and submit to CalOptima for review.<br><br>The UM Program includes a description of the following:<br><br>• Written description of the program structure<br>• Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program<br>• Behavioral healthcare aspects of the program<br>•The program scope and process used to determine benefit coverage and medical necessity<br>• UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities<br>• Information sources used to determine benefit coverage and medical necessity<br>• The Health Network annually evaluates and updates the UM program, as necessary | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5<br><br>NCQA Standards, Utilization Management, UM1 | Annually:<br>February 15 | X | X | X | X | X | |
| UM Work Plan (ICE) | Health Networks shall report progress towards UM program goals semi-annually.<br><br>The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include:<br><br>• Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM Work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5 | Semi-Annually:<br>February 15 and August 15 | X | X | X | X | X | |
| UM Work Plan Current Year (Initial) | Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. | DHCS Medi-Cal Contract, Exhibit A:<br>Attachment 4, Provision 6<br>Attachment 5, Provision 5 | Annually:<br>February 15 (for new year) | X | X | X | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include:<br><br>• Inpatient utilization metrics, and inpatient workplan and report<br>• Referral metrics, and referral workplan and reports<br>• Emergency room (ER) utilization metrics, and ER work plan and reports<br>• Complex case management (CCM) metrics, and CCM work plan and reports<br>• Special needs plan (SNP) metrics, and SNP work plan and reports<br>• Experience (satisfaction) with the UM process work plan and reports<br>• Over/Under utilization and referral timeframe compliance work plan and reports<br>• Turnaround time<br>• Inter-rater reliability evaluation<br>• Other UM work plans and reports<br>• Signature and date approved | | | | | | | | |
| Out-of-Network (OON) Requests | Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.<br><br>The report includes the following:<br><br>• Health Network name, and reporting quarter and year<br>• Date of OON referral request, and referral authorization number<br>• Member name and CIN<br>• Specialist name, NPI, address, and specialty type<br>• Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network)<br>• Resolution status (approved, denied, pending) | APL 20-003: Network Certification Requirements, Network Certification Non-Compliance<br><br>DHCS Medi-Cal Contract, Exhibit A, Attachment 9 | Quarterly:<br>January 25, April 25, July 25, October 25 | X | | | X | X | |
| Kaiser WCM Claim Detail | Kaiser shall submit monthly report of WCM claims payment information.<br><br>The report includes the following:<br>• CalOptima claim number and line, Kaiser claim number)<br>• Provider name, NPI and tax identification number<br>• Member CIN and name<br>• Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units.<br>• Kaiser amount billed and paid<br>• CalOptima amount<br>• Claim remittance code and description<br>• Report month and fiscal year<br>• Check date, number and amount | CalOptima Health Network Contract, Section 9.11<br><br>CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks | Monthly:<br>15th of every month | X | | | | X | |

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| Preclusion List Report for Member Notifications Only | Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks.<br><br>The report includes the following:<br><br>• Line of business (OneCare, OneCare Connect)<br>• Member name, CIN, date of birth, address, and language<br>• Precluded provider name and NPI<br>• Service type (health care services, health care items, or prescriptions)<br>• Preclusion list impacted membership attestation | HPMS Memo, 11/2/18, Preclusion List Requirements<br><br>Final Rule, Vol. 83, No. 73, April 2018 | Monthly:<br>10th of every month | X | X | X | X | X | X |
| Directed Payments File | Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.<br><br>The report includes the following:<br><br>• Claim line ID<br>• Health Network ID, claim number, and claim line number<br>• Member name, CIN, and date of service<br>• Clean claim or encounter received date<br>• Whether an adjustment and previous claim number<br>• Rendering provider name and NPI<br>• Billing provider name, NPI, and Tax ID<br>• Billed CPT/HCPCS code and modifier (if applicable)<br>• Provider billed amount, and whether contracted provider claim<br>• Claim paid amount and adjustment code (if applicable)<br>• Whether fee-for-service or capitated claim<br>• Directed payment amount and paid date, and check or EFT transaction number<br>• Reimbursement disposition (reserved for CalOptima use)<br>• Optional fields (for unique identifiers/specific to HN to help with reconciliation) | APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services<br><br>APL 19-015: Proposition 56 Directed Payments for Physician Services<br><br>APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services<br><br>APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services<br><br>APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations<br><br>APL 20-013: Proposition 56 Directed Payments for Family Planning Services<br><br>CalOptima Policy FF.2011: Directed Payments<br><br>CalOptima Health Network Contract, Attachment E-2 | Monthly:<br>10th of every month | X | | | X | X | |
| Kaiser WCM Rx Detail | Kaiser shall submit monthly report of WCM Rx payment information.<br><br>The report includes the following:<br><br>• Member CIN, date of birth, and MRN (assigned by Kaiser)<br>• Pharmacy NPI and fill date<br>• Prescriber NPI and prescription number<br>• Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag<br>• Drug name, quantity, days of supply, and amount paid<br>• Eligibility for Medi-Cal and CCS<br>• Duplicate record indicator and load date | CalOptima Health Network Contract, Section 9.11<br><br>CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks | Monthly:<br>15th of every month | X | | | | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | | | | | | | | | |
| FDR Compliance Attestation | The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation.<br><br>The report includes the following:<br>• Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE)<br>• Organization name<br>• Applicability of General and HIPAA Compliance and FWA Training<br>• Applicability of Compliance Plan and Code of Conduct Requirements<br>• Authorized Signature, Name, Email and Date<br>• Organization Name | CalOptima Policy: HH.2023: Compliance Training<br><br>CalOptima Health Network Contract, Sections:<br>3.26<br>3.27<br><br>Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual;<br><br>8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS;<br><br>9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States;<br><br>7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States. | Initial upon contracting;<br>Annually thereafter | X | X | X | X | X | X |
| Claims Timeliness Report | Health Networks shall submit a monthly claims payment performance (timeliness) report.<br><br>The report includes the following:<br>• Health Network name, management company name and report preparer name, title and email.<br>• The reporting year, quarter and month(s).<br>• The number of paid, contested and member-denied claims.<br>• The number of claims paid within timeliness requirements.<br>• The number of unprocessed claims on hand.<br>• The total number of all claims received<br>• The number of emergency room (ER) claims paid, contested and denied.<br>• The number of ER claims paid timely.<br>• Certification signed by principal officer, including name, title, phone and email. | CalOptima Health Network Contract, Section 2.7.8<br><br>Kaiser HMO Contract, Section 2.3.8<br><br>CalOptima VSP Contract, Section 3.8 | Monthly:<br>15th of every month<br><br>Quarterly:<br>January 30, April 30, July 30, October 30 | X | X | X | X | X | X |
| 274 Provider Directory – Kaiser | Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide.<br><br>The report includes the following:<br>• Provider and Group name, NPI, TIN, taxonomy and effective/term date(s).<br>• Site name, bed counts, membership min/max, demographics, language(s) spoken, schedule, ownership.<br>• Provider name, membership min/max, demographics, language(s) spoken, schedule, telehealth status. | CalOptima Policy: HH.2003 Health Network and Delegated Entity Reporting;<br><br>CalOptima Policy: EE.1101 Additions, Changes, and Terminations to Provider Information CalOptima Provider Directory and Web-based Directory;<br><br>DHCS Medi-Cal Contract: Exhibit A, Attachment 3; | Monthly:<br>2nd of every month | X | | | | X | |

For 20210506 BOD Review Only

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | | NCQA Element MED14B: Pharmacy Directory Data;<br><br>NCQA Element MED14C: Behavioral Healthcare Directory Data;<br><br>NCQA Element MED14D: Long-Term Services and Supports Provider Directory Data | | | | | | | |
| Provider Termination Quarterly Report - Kaiser | Monitor Kaiser's adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice.<br><br>The report includes the following:<br>• Termination Date<br>• Providers Name<br>• Provider Type<br>• Did the Termination Result in One or More of the Annual Network Certification Components to No Longer be Compliant? (Y/N)<br>• Impacted County<br>• Date Member Notice was mailed<br>• Number of Members Impacted (As of Date Notice Received)<br>• Number of Members that were Reassigned Outside of the Time and Distance Standards<br>• Is an Accessibility Analysis or AAS Request Being Submitted with this Report?<br>• Enter the Number of Days' Notice the Provider gave the MCP<br>• Enter the Provider ID<br>• Enter the Provider NPI<br>• Enter the Provider Termination Reason<br>• Indicate if the Provider is CCS Paneled? (Y/N) | CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting;<br><br>NCQA Element MED1H: Notification of Termination of a Practitioner or Practice Group Standard | Quarterly:<br>10th of the month following the end of each quarter | X | | | | X | |
| UM Retrospective Appeal Universe | Monitor the Health Networks' handling of first level UM Provider Appeals.<br><br>The report includes the following:<br>• Member Name<br>• ID Number (CIN)<br>• LOB<br>• Request Type<br>• Date the Request was Received<br>• Time the request was received<br>• Was the AR requested as expedited?<br>• Was the AR processed under the expedited timeframe?<br>• Was a timeframe extension taken?<br>• Procedure Codes Requested<br>• Diagnosis Code(s), (ICD-10)<br>• Decision Date<br>• Decision Time<br>• Action (Approved, Modified, Denied) | CalOptima Health Network Contract Section 4.9.7: Provider Level 1 UM Appeals | Quarterly:<br>10th of the month following the end of each quarter | X | X | X | X | X | |

For 20210506 BOD Review Only

# Timely and Appropriate Submission Grid – Supplemental Attachment

| REPORT NAME | DESCRIPTION/REQUIREMENT | CITATION | REPORT FREQUENCY | LINE OF BUSINESS | | | REPORT REQUIREMENT INDICATOR | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Medi-Cal | OneCare | OneCare Connect | Health Networks (Except Kaiser) | Kaiser | VSP |
| | • Authorization Number<br>• Provider Notification Date<br>• Provider Notification Time<br>• Provider Written Notification Date<br>• Provider Written Notification Time<br>• Member Written Notification Date<br>• Member Written Notification Time<br>• Threshold Language<br>• Was an Appeal Received (Y/N)?<br>• Date Appeal was Received<br>• Date of Appeal Decision<br>• Decision (Approved, Modified, Denied)<br>• Provider Written Appeal Notification Date | | | | | | | | |
| Semi-Annual Site Visit Report - Kaiser | The report captures sites that received an Initial or Periodic FSR/MRR.<br><br>The report includes the following:<br>• Site ID<br>• Site Address<br>• Suite No.<br>• City<br>• State<br>• Zip<br>• County<br>• Plan#<br>• Health Plan Name<br>• Site Specific Certification #1-#4<br>• Provider Phone #<br>• Clinic Type<br>• Reviewer ID | DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review<br><br>NCQA Elements MED 3B and MED 5B | Semi-Annually: February 15 and August 15 | X | | | | X | |
| Kaiser Pharmacy Monitoring Report | Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates.<br><br>The report includes the following:<br>• Samples of pharmacy information as displayed on Kaiser's website and/or member portal.<br>• Samples showing updates to pharmacy information displayed on Kaiser's website and/or member portal. | NCQA Elements ME 5A, ME 5B, ME 5C, ME 5D | Semi-Annually: April 1 and October 1 | X | | | | X | |

For 20210506 BOD Review Only



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*This Item was Deleted*

# CalOptima Board Action Agenda Referral

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
15. Consider Approval of CalOptima Policy to Establish a Process and Criteria for Health Network Contract Model Changes

**Contacts**
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

**Recommended Actions**
Approve CalOptima Policy EE.1150: Health Network Contract Model Changes

**Background**
CalOptima utilizes three different delegation contract models for its Medi-Cal, OneCare and OneCare Connect (OCC) programs, each entailing varying levels of financial risk: Shared-Risk Groups (SRG), Physician Hospital Consortia (PHC), and Health Maintenance Organizations (HMO). Under the SRG model, the Physician Group receives capitation only for delegated physician services as defined in each SRG's division of financial responsibility (DOFR). Under this model, CalOptima is financially responsible for Hospital services, and there is a contractual risk pool. Under the PHC Health Network model, Physician Group and Hospital partners separately contract with CalOptima and are capitated only for the services delegated to them under their respective contracts. Under the HMO model, the HMO is a single entity that may accept risk for all delegated contracted covered services as a Department of Managed Health Care (DMHC) licensed HMO plan. Both the PHC and HMO models are full risk models, whereas the SRG model is shared risk between Health Networks and CalOptima.

At its August 6, 2020 meeting, the CalOptima Board of Directors authorized currently participating PHC Health Networks to change their contract risk model for the Medi-Cal program to an HMO model, subject to the successful completion of CalOptima's readiness assessment and obtaining DMHC licensure. In addition to the PHC Health Networks, staff have received requests from other Health Networks currently contracted under other models seeking to change their contract model.

**Discussion**
To operationalize the Board's directive from its August 6, 2020 Meeting and to develop a defined process through which a Health Network may request a change to its contract model, staff developed proposed policy EE.1150: Health Network Contract Model Changes. This policy outlines the process for a contracted Health Network to request a change in its contract model and the steps required for CalOptima to review, consider, approve, and implement the new Health Network contract model.

As drafted, the policy applies to the Medi-Cal, OneCare, and OneCare Connect programs. The policy includes two attachments allowing a Health Network to submit a model change request form and a proposal for meeting operational standards under the requested contract model.

- Attachment A: Health Network Contract Model Change Request Form
- Attachment B: Health Network Contract Model Change Proposal

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The Health Network Contract Model Change Proposal was developed considering the 2013 CalOptima Delivery System Expansion Request for Proposal (RFP) Scope of Work (SOW), which included evaluative criteria in the areas of financial solvency, licensure, management structure, provider network capacity, quality performance and infrastructure for operations. Staff made updates to the criteria and added current performance as an evaluative measure, including quality standing, compliance with audit requirements, and outcomes of delegation oversight and monitoring.
At a high level, the policy requires successful completion of the following steps in order for CalOptima to consider requested Health Network contract model changes:

1. Health Network submission of completed request and proposal for model change at least one year prior to the proposed contract effective date.
2. Financial viability review of model change request conducted by the CalOptima Finance Department and CalOptima's Chief Financial Officer (CFO).
3. Executive management review of the model change for alignment with CalOptima's strategic priorities and Orange County's health care landscape.
4. Departmental review of the model change proposal.
5. Review of the model change request and proposal by the CalOptima Audit & Oversight Committee and the CalOptima Compliance Committee.
6. Report of the Health Network model change request and proposal to the CalOptima Board of Directors.
7. Readiness assessment conducted by the CalOptima Audit & Oversight department.
8. Approval of the Health Network readiness assessment by the CalOptima Audit & Oversight Committee and the CalOptima Compliance Committee.
9. Report of the Health Network readiness assessment's outcome and recommendation from CalOptima staff and committees to the CalOptima Board of Directors for approval to implement the contract model change.
10. Notification of the Health Network model change to applicable regulators.
11. Execution of new Contract for Health Care Services under the approved contract model.

Staff will keep the CalOptima Board of Directors apprised of all health network contract model change requests. Once a request is received, the CalOptima Board of Directors will be notified of the Health Network's request and staff's recommendation based on the review and assessment of the information submitted by the Health Network. Once the readiness assessment is complete and approved by staff, the CalOptima Board of Directors will be notified of the outcome of the readiness assessment and staff will request approval from the Board to finalize the contract model change and execute the contract under the new model.

Staff is recommending that the Board consider approving this policy to memorialize the process through which a Health Network may request contract model change and the criteria by which Health Network model change requests will be evaluated. This allows CalOptima staff to work directly with the Health Network seeking to change contract risk arrangement, including the initiation and completion of the readiness assessment. Contract model change requests will only be submitted to the Board for consideration if the Health Network submits a complete proposal that is financially viable, is in

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alignment with CalOptima's strategic priorities, and meets all applicable programmatic, regulatory, licensing, and readiness requirements.

**Fiscal Impact**

The recommended action to approve CalOptima Policy EE.1150 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

To the extent there is any fiscal impact due to a Health Network contract model change, Staff will address the impact in separate Board actions or in future operating budgets.

**Rationale for Recommendation**

Approval of Policy EE.1150: Health Network Model Changes will memorialize the process through which a Health Network may request contract model change and the criteria by which Health Network model change requests will be evaluated.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Entities covered by this recommended action
2. Policy EE.1150: Health Network Contract Model Changes (Redlined and Clean Versions), which includes:
   - Attachment A: Health Network Contract Model Change Request Form
   - Attachment B: Health Network Contract Model Change Proposal

*/s/ Richard Sanchez* — *04/29/2021*

**Authorized Signature** — **Date**

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# ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Heritage Provider Network, Inc. | 8510 Balboa Blvd. Ste. 285 | Northridge | CA | 91325 |
| Monarch Health Plan, Inc. | 11 Technology Dr. | Irvine | CA | 92618 |
| Prospect Health Plan, Inc. | 600 City Parkway West Ste. 800 | Orange | CA | 92868 |
| CHOC Physicians Network and Children's Hospital of Orange County | 1120 West La Veta Avenue Ste. 450 | Orange | CA | 92868 |
| Family Choice Medical Group, Inc. | 7631 Wyoming St. Ste. 202 | Westminster | CA | 92683 |
| Fountain Valley Regional Hospital and Medical Center | 17100 Euclid St. | Fountain Valley | CA | 92708 |
| AMVI Care Health Network | 600 City Parkway West Ste. 800 | Orange | CA | 92868 |
| Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc. | 5785 Corporate Ave. | Cypress | CA | 90630 |
| Kaiser Foundation Health Plan | 393 E Walnut St. | Pasadena | CA | 91188 |
| Talbert Medical Group, P.C. | 2175 Park Place | El Segundo | CA | 90245 |
| ARTA Western California, Inc. | 2175 Park Place | El Segundo | CA | 90245 |
| United Care Medical Group, Inc. | 600 City Parkway West | Orange | CA | 92868 |
| AltaMed Health Services Corporation | 2040 Camfield Ave. | Los Angeles | CA | 90040 |

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| | |
|---|---|
| Policy: | EE.1150 |
| Title: | **Health Network Contract Model Changes** |
| Department: | Network Operations |
| Section: | Health Network Relations |
| *CEO Approval:* | */s/* |
| Effective Date: | TBD |
| Revised Date: | Not Applicable |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☒ OneCare Connect<br>☐ PACE<br>☐ Administrative |

For 20210506 BOD Review Only

## I. PURPOSE

This policy outlines the process for contracted Health Networks to request a change in contract model, and the steps required to review, approve, and implement the new Health Network contract model.

## II. POLICY

A. Health Networks may contract with CalOptima under one of the following models, subject to CalOptima's approval and fulfillment of applicable readiness and implementation requirements:

1. Shared Risk Medical Group (SRG);

2. Physician Hospital Consortium (PHC); or

3. Full Risk Health Maintenance Organization (HMO).

B. Existing Health Networks are not required to operate under the same model for all contracted lines of business, subject to CalOptima's discretion and approval.

C. Health Networks may request to change contract model for their contracted line(s) of business, subject to CalOptima's approval, as outlined in this Policy.

1. Health Networks that submit the contract model change request form and proposal are not guaranteed an approval to move forward with the contract model change.

2. CalOptima reserves the right to deny any request for change in health network contract model at its sole and absolute discretion. Nothing in this Policy (and its attachments) is intended to indicate that any change in health network contract model submission is guaranteed to be approved.

D. SRG or HMO Health Networks seeking to change to a PHC model must partner with an existing CalOptima PHC hospital partner to be considered for the contract model change.

E. Health Networks seeking to change contract model must submit a proposal for operating under the requested contract model using the criteria outlined in Attachment B of this Policy. Categories of

criteria for considering approval of Health Network contract model changes include, but are not limited to:

1. Compliance with network adequacy and access standards;

2. Financial solvency;

3. Compliance with existing CalOptima and regulatory requirements;

4. Strategies for meeting quality-related measures; and

5. Infrastructure to support reporting and administration of services (e.g., claims adjudication, utilization management, information technology).

F. Health Networks requesting to change contract models must adhere to CalOptima's designated timeframes for readiness assessment and implementation unless an extension request is approved by CalOptima.

G. Health Networks must fulfill all licensure, readiness assessment, policy, contractual, and regulatory requirements to contract with CalOptima under the requested contract model for the respective line(s) of business.

H. Health Network contract model changes shall be subject to approval by the CalOptima Board of Directors.

I. Health Networks whose contract model change request is denied may submit a request for reconsideration to CalOptima, as outlined in Section III.G. this Policy.

## III. PROCEDURE

A. Submission and Review of Contract Model Change Request

1. Existing Health Networks may submit a written request to change their contract model to the CalOptima Health Network Relations Department by:

   a. Completing a Health Network Contract Model Change Request Form ("Form") (Attachment A); and

   b. Submitting a complete proposal that addresses all criteria outlined in the Health Network Contract Model Change Proposal ("Proposal") (Attachment B).

2. Health Networks seeking to change contract model must submit the Form and Proposal to CalOptima at least one (1) year in advance of the intended new contract model effective date.

   a. Exceptions to the one (1) year timeframe requirement may be considered on a case-by-case basis at the discretion of CalOptima's Executive Management Team.

3. The CalOptima Director of Network Management shall review the Form and Proposal for completeness within five (5) business days of receipt from the requesting Health Network.

4. Health Network requests for contract model changes will be denied if the Form or Proposal are incomplete.

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5. Health Networks may resubmit the completed Form and/or Proposal as outlined in Section III.H. of this Policy.

6. If the Form and Proposal are deemed complete, the documents shall be forwarded to the CalOptima Finance Department for review.

B. Preliminary Financial Review

1. The CalOptima Finance Department and Chief Financial Officer (CFO) shall conduct a financial analysis and make a preliminary determination of the financial viability of the Health Network's contract model change request within ten (10) business days of receipt of the Form and Proposal.

2. If the CalOptima Finance Department and/or CFO determine the Health Network's model change request is not financially viable based on the documentation provided in the Proposal, the CalOptima Director of Network Management shall notify the Health Network.

3. Upon notification that the model change request is not financially viable, Health Networks may submit additional financial documentation within ten (10) business days as outlined in Section III.G. of this Policy.

C. Executive Management Team and Departmental Review

1. If the Health Network's contract model change request is deemed financially viable, CalOptima's Executive Management Team shall determine whether the Health Network's request aligns with CalOptima's strategic priorities and the needs of its healthcare delivery system.

2. If CalOptima's Executive Management Team determines the Health Network's request does not align with CalOptima's strategic priorities and the needs of its healthcare delivery system, the CalOptima Director of Network Management shall notify the Health Network, in writing, of the reason(s) for denying the contract model change request.

3. Health Networks may submit a written request for reconsideration within ten (10) business days, as outlined in section III.G. of this Policy.

4. If the CalOptima Executive Management team determines the Health Network's request aligns with CalOptima's strategic priorities and the needs of its healthcare delivery system, the Proposal shall be evaluated by impacted CalOptima departments within ten (10) business days of receipt of the Proposal.

D. Committee Review

1. Upon completing the preliminary financial review, Executive Management Team review, and departmental review of the Health Network's contract model change request, the CalOptima Director of Network Management shall present the request to the CalOptima Audit & Oversight Committee (AOC) for consideration.

2. CalOptima Network Management and the AOC shall make a formal recommendation to the CalOptima Compliance Committee for consideration of the Health Network's request.

3. The CalOptima Director of Network Management shall notify the Health Network, in writing, of the outcome of the Compliance Committee's review, which can include approval of the request, denial of the request, or pending of the request for additional information.

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a. The written communication shall include the rationale for denial or pending of the Health Network's request.

4. If the Health Network's request is denied, a Health Network may submit a written request for reconsideration within ten (10) business days, as outlined in section III.G. of this Policy.

5. If the Health Network's request is pended for additional information, a Health Network must submit additional documentation within ten (10) business days, as outlined in section III.H. of this Policy.

E. Board of Directors Notification of Health Network Contract Model Change Request

1. Following completion of the preliminary financial review, Executive Management Team review, departmental review, and committee review of the Health Network's contract model change request and proposal, CalOptima Network Operations shall inform the Board of Directors of staff's recommendation on the Health Network model change request, based on the information submitted by the Health Network.

2. Execution of the Health Network contract model change request is subject to approval by CalOptima's Board of Directors, as outlined in Section III.F. of this Policy.

F. Readiness Activities and Contract Implementation

1. Following approval from the CalOptima Board of Directors to pursue the model change request based on the information submitted by the Health Network, the CalOptima Health Network Relations Department shall:

a. Request project management resources from CalOptima's Information Services (IS) Department to develop a project plan and work with impacted departments to operationalize the Heath Network's new contract model.

i. The CalOptima Health Network Relations Department and IS Department shall monitor deliverables and milestones for the implementation of the new heath network contract model.

b. Request the CalOptima Regulatory Affairs & Compliance Department notify the Department of Health Care Services (DHCS) and/or Centers for Medicare & Medicaid Services (CMS) of the proposed Health Network contract model change and the proposed contract effective date.

i. Notification to DHCS and/or CMS shall occur as soon as practicable, but no later than ninety (90) calendar days from the proposed contract effective date.

2. The CalOptima Audit & Oversight (A&O) Department shall conduct a readiness assessment of the Health Network to determine compliance with CalOptima and regulatory requirements and present the findings of the readiness assessment to the AOC.

3. Once the readiness assessment is approved by the AOC, a formal recommendation shall be made to the CalOptima Compliance Committee for final approval of the Heath Network's contract model change request and readiness for implementation.

a. The CalOptima Director of Network Management shall notify the Health Network of the CalOptima Compliance Committee's decision.

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4. If the Health Network's readiness assessment is approved by the CalOptima Compliance Committee, CalOptima Network Operations shall request approval from CalOptima's Board of Directors to finalize the contract model change request by executing a new Contract for Health Care Services under the new contract model.

   a. The CalOptima Director of Network Management shall notify the Health Network of the CalOptima Board of Director's decision to move forward with finalizing the contract model change request.

5. If CalOptima's Board of Directors approves staff's recommendation to finalize the contract model change request, the CalOptima Contracting Department shall work with the Health Network to execute a Contract for Health Care Services under the Health Network's new model for the appropriate line of business.

6. If CalOptima's Board of Directors requests additional information before approving staff's recommendation to finalize the contract model change, the Health Network must submit additional information within ten (10) business days, as outlined in Section III.H. of this Policy.

7. If CalOptima's Board of Directors does not approve staff's recommendation to finalize the contract model change, the Health Network must wait until the following contract year to submit another model change request form and proposal to CalOptima for consideration.

8. If the readiness assessment is not approved by the AOC or Compliance Committee, or conditionally approved pending resolution of outstanding readiness activities, the CalOptima A&O Department shall work with the Health Network on remediation, as outlined in CalOptima Policy HH.2005Δ: Corrective Action Plan.

9. If the Health Network is unable to timely remediate outstanding readiness activities that would impair its ability to adequately serve the needs of CalOptima Members or providers under the new contract model, then the model change implementation will not proceed until the Health Network has corrected all specified deficiencies.

   a. CalOptima Network Operations shall inform the Board of Directors of the delay of the Health Network model change request based on pending readiness activities and provide a recommendation for rejecting or extending the timeframe for the Health Network to meet required readiness activities.

G. Health Network Request for Reconsideration

1. If a Health Network request for contract model change is denied, the Health Network may submit a written request for reconsideration to CalOptima's Director of Network Management within ten (10) business days of notification of the denied contract model change request.

2. Reconsideration of Health Network model change request denials are subject to approval by CalOptima's Executive Management Team.

H. Health Network Request for Additional Information

1. If a Health Network request is pended for additional information, the Health Network must submit additional documentation to the CalOptima Director of Network Management within ten (10) business days of notification of the pended contract model change request.

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2. Failure to submit additional information within ten (10) business days of notification from CalOptima may result in denial of the contract model change request.

## IV. ATTACHMENT(S)

A. Health Network Contract Model Change Request Form
B. Health Network Contract Model Change Proposal

## V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers of Medicare & Medicaid Services (CMS)
E. Knox-Keene Health Care Service Plan Act of 1975
F. CalOptima Policy FF.3002: Financial Oversight
G. CalOptima Policy GG.1619 Delegation Oversight
H. CalOptima Policy HH.1101: CalOptima Provider Complaint
I. CalOptima Policy HH.2005Δ: Corrective Action Plan
J. CalOptima Policy MA.9006: Provider Complaint Process

## VI. REGULATORY AGENCY APPROVAL(S)

None To Date

## VII. BOARD ACTION(S)

None To Date

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | TBD | EE.1150 | Health Network Contract Model Changes | Medi-Cal<br>OneCare<br>OneCare Connect |

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1 **IX. GLOSSARY**
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| Term | Definition |
|---|---|
| Executive Management Team | For the purposes of this Policy, refers to CalOptima executive staff responsible for evaluating Health Network contract model change requests, including the Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Operating Officer, Executive Director of Operations, Executive Director of Network Operations, Executive Director of Clinical Operations, and Executive Director of Compliance. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. |
| Member | A beneficiary enrolled in a CalOptima program. |
| Shared Risk Medical Group (SRG) | A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services. |

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## Health Network Contract Model Change Request Form

This form applies to existing health networks that hold an executed Contract for Health Care Services with CalOptima that is valid on the date of form submission. Please complete this form in its entirety and submit to CalOptima, along with a proposal that contains the necessary Contract Model Change Proposal criteria.

### 1. Health Network Contract Model Request

| Current Health Network Name: | | | |
|---|---|---|---|
| Current Contract Model: | ☐ PHC | ☐ SRG | ☐ HMO |
| Proposed Health Network Name: | | | |
| Proposed Contract Model: | ☐ PHC | ☐ SRG | ☐ HMO |

*For contract model change to PHC:*

| Proposed Hospital Partner Name: | | |
|---|---|---|
| Does the hospital currently hold accreditation by The Joint Commission or a comparable accrediting body? | ☐ Yes | ☐ No |

*For contract model change to HMO:*

| Does the health network currently hold a Knox-Keene Full Service Health Plan license? | ☐ Yes | ☐ No |
|---|---|---|

*If No:*

| Date of submission of license modification application to DMHC | |
|---|---|
| Anticipated date of DMHC award of license modification | |

### 2. **Signature** (The health network Chief Executive Officer, President, or agent authorized to sign contracts on behalf of the health network, must sign this form)

| Name: | |
|---|---|
| Title: | |
| Signature: | |
| Date: | |

*For contract model change to PHC:* **Signature** (The hospital Chief Executive Officer, President, or agent authorized to sign contracts on behalf of the hospital, must sign this form)

| Name: | |
|---|---|
| Title: | |
| Signature: | |
| Date: | |

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3. **Model Change Proposal** (Submit a model change proposal addressing each requirement or question listed on the Health Network Contract Model Change Proposal Criteria document)

4. **Additional Documentation** (Collect and submit with this form)
   - Updated W-9 Form.
   - If changing contract model to HMO:
     - Copy of Knox-Keene Full Service Health Plan license certificate; or
     - Copy of license modification application to DMHC.

5. **Submit the completed signed form, new health network request proposal and additional documentation via email to CalOptima's Health Network Relations department at HealthNetworkDepartment@caloptima.org with the subject line: Health Network Contract Model Change.**

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**Health Network Contract Model Change Proposal Criteria**

Health networks requesting to change contract model must submit a proposal to CalOptima that addresses all the criteria outlined below, in addition to submitting the Health Network Contract Model Change Request Form. To facilitate review, health networks should clearly identify where each of the elements can be found within the proposal.

**Note**: A separate proposal must be submitted for each line of business contract requested for model change. The proposal submitted must address how these criteria will be met under the new proposed contract model for each line of business requested for a contract model change.

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## I. References, Financial, Licensing and Accreditation Requirements

**A.** Submit the name, title, address, email, and telephone number of a contact person for each Medi-Cal and/or Medicare managed care contract held within the last five (5) years.

**B.** Demonstrate the following, as outlined in CalOptima policy FF.3002: Financial Oversight, and the desired contract model for Senate Bill (SB) 260 compliance.

**1)** Financial solvency requirements for a current network to be in good standing by meeting current Risk-Based Organization (RBO) requirements:

**a)** Maintain positive working capital (i.e., Current Ratio is greater than or equal to 1.0).
**b)** Maintain positive Tangible Net Equity.
**c)** Cash to Claims Ratio is greater than or equal to .75
**d)** Incurred but not reported (IBNR) is estimated and documented on a monthly basis.

**2)** Submit all applicable interim unaudited financial statements.

**a)** Include financials submitted to the Department of Managed Health Care (DMHC) for RBO reporting.

**3)** Agree to abide by financial security reserve and/or capitation withhold requirements, as applicable for the desired contract model.

**C.** Demonstrate the following licensing and accreditation requirements are in place, as appropriate.

**1)** For changes to physician hospital consortium (PHC) model: Hospital partner must be accredited by The Joint Commission or a comparable accrediting body.

2) For changes to health maintenance organization (HMO) model: Health Network must be Knox Keene licensed or have applied for a license modification.

   a) Submit copy or evidence of Knox Keene licensure application to the Department of Managed Health Care (DMHC).

## II. Management Structure

A. Provide a description of each of the following elements of its organizational structure and/or the organizational structure of its Management Services Organization (MSO), as applicable. Proposals must include:

   1) Medical Group Structure - including physician extenders.
   2) Physician Reporting Structure.
   3) Physician Outreach Process and Strategy.
   4) Use of Clinical Guidelines.
   5) Physician and other Provider Payment Structures (e.g. capitated, bundled payments etc.)
   6) Physician Incentive Programs.
   7) Physician and Provider Data Management.
   8) Physician and Provider Performance Monitoring.

B. Provide the health network's ownership, employee and client information indicated below:

   1) Number of employees in the health network's organization and/or the health network's MSO.
   2) List of the other Management company clients, and location of offices. Include information on parent organization, affiliates, and subsidiaries.
   3) List the names and addresses of all persons (individual and/or corporate) who have a *Controlling Interest in the health network.
   4) List the names and addresses of all, vendors, or providers in which the health network has a controlling interest or ownership. Indicate if any of these individuals have been convicted of a crime related to or been terminated from a federal or state medical program.

C. If applying for PHC contract model, provide the hospital partner's ownership, employee and client information indicated below:

   1) Number of employees in the hospital partner's organization and/or the hospital partner's management company.
   2) List of the other Management company clients, and location of offices. Include information on parent organization, affiliates, and subsidiaries.
   3) List the names and addresses of all persons (individual and/or corporate) who have a Controlling Interest in the hospital partner.

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4) List the names and addresses of all, vendors, or providers in which the hospital partner has a controlling interest or ownership. Indicate if any of these individuals have been convicted of a crime related to or been terminated from a federal or state medical program.

**As defined by the Centers for Medicare & Medicaid Services (CMS), "Controlling Interest" includes, but is not limited to, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater of outstanding stock, or holders with such position or relationship who may have a bearing on the operation or administration of a medical service-related business.*

## III. Provider Network

### A. *Provider Network Roster*

1) Submit, in an acceptable electronic format (excel or csv), the health network's proposed provider network. Provide all the applicable elements in the following order with one field for each element: National Provider Identifier (NPI) #, license #, last name, first name, group name (if applicable), street address, city, state, zip code, specialty, Primary Care Physician (PCP) (yes or no), practice open for new patients (yes or no), Registered with Medi-Cal (yes or no), hospital affiliations (up to five, one per field) and office hours.

2) Submit, in an acceptable electronic format (Excel spreadsheet or csv), the health network's proposed hospital, urgent care and ancillary provider network. Provide all the applicable elements in the following order with one field for each element: Name of provider, street address, city, state, zip code, type of service, NPI#, Taxpayer identification number (TIN)#, registered with Medi-Cal (yes or no), Medicare certified (yes or no).

### B. *Provider Network Adequacy and Monitoring*

1) Describe the proposed process for the implementation and monitoring of the provider network to ensure it is adequate in size and scope to meet the needs of the CalOptima population. The description must include how the health network plans to hold their provider network accountable to standards outlined in the CalOptima contract, including waiting times for care and appointments, and provider to member ratios.

## IV. Quality Performance Strategy & Results - Demonstrated Ability to Ensure Members Receive High Quality Care Appropriate for their Needs

### A. *Proposed Quality Performance Strategy*

1) Describe the health network's proposed strategy for meeting performance benchmarks and requirements from CMS and the Department of Health Care Services

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(DHCS), as applicable and as established in the CalOptima contract and Delegation Agreement to ensure members receive high-quality care appropriate for their needs.

**2)** Include examples of proposed strategies for engaging providers and subcontractors to accomplish these objectives; how the heath networks plans to incorporate cultural awareness, language assistance and disability accommodations within their organization and in the delivery of care to CalOptima members; and, community health improvement activities the health network plans to engage in, including any collaborative partnerships with community-based organizations.

**3)** Indicate any additional services the health network plans to provide to members above and beyond CalOptima's requirements. Note: information on these services may be shared with CalOptima members during the enrollment period.

**4)** Indicate the method of evaluating the effectiveness of their proposed quality performance strategy.

## V. Infrastructure

### A. *Demonstrated Ability to Manage a Medi-Cal and/or Medicare, or Similar Populations through a Managed Care Delivery System*

**1)** Provide a narrative description of the health network's proposed medical management, operational and financial organizational structure for managing CalOptima's Programs under the desired contracting structure. Include details on any intended contract or affiliation with an MSO that will administer the health network's CalOptima business.

**2)** Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the contract as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this contract model change and illustrate the lines of authority. For key staff positions that are not currently filled please provide job descriptions, including qualifications and duties, and an indication of when the position will be filled. Indicate the city and state in which the key staff will be based (i.e., conduct more than 50% of their work).

**3)** Provide a statement of whether the health network intends to use subcontractors and if so, a clear estimation of what percentage of the CalOptima contract responsibilities will be subcontracted (e.g. claims, utilization management, information systems, etc.)

**4)** Include the names and mailing addresses of the subcontractor(s) and a description of the scope and portions of the work the subcontractors will perform. Indicate the city and state from which they will perform the work.

**5)** Describe how the health network intends to monitor and evaluate subcontractor performance.

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**B. *Coordination of Care Access Programs and Carve Out Services***

**1)** Describe the health network's relationships and systems in place to coordinate care with Medi-Cal Carve-Out Services (e.g. Medi-Cal home and community based services (HCBS) etc.) and community based organizations according to CalOptima's Division of Financial Responsibility (DOFR) under the new contract model.

**2)** Describe the health network's proposed, or existing, process for coordinating care for Medi-Cal or Duals (Medi-Medi) members/patients residing in skilled nursing facilities.

**C. *Demonstration of Information Technology, Data Management, Clinical Technology Innovation, Electronic Data Exchange, and Health Information Exchange***

**1)** Describe information technology systems currently utilized and/or proposed subcontractors, including but not limited to, case management systems, utilization management systems, practice management systems, Electronic Health Records (EHR), claims systems, reporting systems, and/or web portals. List out each system, current functionality and use, and any plans for changes or upgrades.

**2)** Describe systems' capability to process claims under a primary and secondary coverage and to administer responsibilities within each of the regulatory guidelines.

**3)** Describe systems' functionality to process payment under primary coverage and transition the same claim to process under coordination of benefits (COB) as the secondary coverage.

**4)** Describe data management capacity, including use of predictive modeling, data mining, member stratification, data capturing, or other decision support tools utilized to improve quality, monitor patient care and design interventions.

**5)** Describe proposed use of Clinical Technology Innovation to improve care and expand access through alternative care options, e.g. telemedicine, home monitoring, eConsult, etc.

**6)** Describe experience with, and capacity to, exchange data electronically including, but not limited to, electronic claims submission, electronic encounter data submission, electronic authorization feeds, etc.

**7)** Describe ability to submit and/or receive ANSI 5010 standard transaction sets. Specify which formats they currently support/are in production with and any plans for changes or upgrades.

**8)** Specify whether the health network or a clearinghouse will be submitting some or all the ANSI 5010 837 encounter data files to CalOptima.

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**9)** Describe maturity in the area of Health Information Technology, including but not limited to, ePrescribing, physician level of reaching Meaningful Use (as defined by CMS), Health Information Exchange participation, etc.

**10)** Describe proposed physician education training programs for the submission of encounter data specific to Medicare and any systems or technology solutions that support the collection of Medicare encounter data.

**11)** If the health network will use new or upgraded systems to conduct the following functions, describe the management information system(s) that will be utilized including the name of the system, whether the system is integrated with all other functions or stands along, and the capability of each of the identified functions.

- **a)** Utilization management.
- **b)** Medical management.
- **c)** Credentialing.
- **d)** Quality management.
- **e)** Claims management, processing and adjudication.
- **f)** Encounter data processing.
- **g)** Member services and customer service functions.
- **h)** Electronic data interchange.

**12)** For each of the functions listed in item (V.C.10) above, provide examples of systems the health network or subcontracted MSO has implemented for other contracts, including descriptions of system functionality and the capacity to meet regulatory standards (e.g. timely claims payment, denial letters, HIPAA, etc.)

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**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken May 6, 2021**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

16. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

**Contacts**

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

**Recommended Action**

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend CalOptima's contract with Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2021.

**Background**

CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized the Chief Executive Officer to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. On June 4, 2020, the Board exercised the second one-year option. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2021.

**Discussion**

Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, the State budget, California Advancing and Innovating Medi-Cal (CalAIM) proposal, CalOptima Program of All-Inclusive Care for the Elderly (PACE), and COVID-19 legislation and State response.

As proposed, the recommended action authorizes extension of the Edelstein Gilbert Robson & Smith's contract for an additional one-year term (i.e., the third of four one year extension options included in the contract), with each extension option exercisable at CalOptima's sole discretion under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**

Management will include expenses related to the recommended action to extend the contract from July 1, 2021, through June 30, 2022, with Edelstein Gilbert Robson & Smith for state legislative advocacy services in the upcoming CalOptima Fiscal Year 2021-22 Operating Budget.

**Rationale for Recommendation**

State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Entity Covered by Recommended Action
2. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services
3. 18-10701 Edelstein Gilbert Robson Smith Contract
4. Board Action dated June 6, 2019, Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith
5. 18-10701 Edelstein Gilbert Contract Amendment 1
6. Board Action dated June 4, 2020, Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith
7. 18-10701 Edelstein Contract Amendment 2
8. 18-10701 Edelstein Amendment No 3

*/s/ Richard Sanchez* *04/29/2021*

**Authorized Signature** **Date**

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**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Edelstein Gilbert Robson & Smith LLC | 1127 11th Street, Suite 1030 | Sacramento | CA | 95814 |

# CalOptima Board Action Agenda Referral

**Action To Be Taken June 7, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

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

**Recommended Actions**
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

**Discussion**
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

**Rationale for Recommendation**
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

*/s/ Michael Schrader* — *5/30/2018*
**Authorized Signature** — **Date**

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CONTRACT NO. 18-10701

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, dba CALOPTIMA and

EDELSTEIN, GILBERT, ROBSON & SMITH, L.L.C.

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Edelstein, Gilbert, Robson & Smith, L.L.C. a Limited Liability Company (LLC), hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide State Legislative Advocacy Services for CalOptima, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP") 18-039, if applicable, inclusive of any revisions, amendments and addenda thereto, and (iii) CONTRACTOR's proposal dated April 13, 2018. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated April 13, 2018.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

| Name | Function/Title |
|---|---|
| Don Gilbert | Partner |
| Trent Smith | Partner |

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,200,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single

transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap,

disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and

such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence no later than 07/01/2018 and shall continue in full force and effect through 06/30/2019, ("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 four (4) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise),and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services,and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative

purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving

services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

| To CONTRACTOR: | To CalOptima: |
|---|---|
| Edelstein, Gilbert, Robson & Smith, LLC | CalOptima |
| 1127 11th Street, Suite 1030 | 505 City Parkway West |
| Sacramento, CA 95814 | Orange, CA 92868 |
| Attention: Trent Smith | Attention: Mark Finch, C.P.M., CPPO, CPSM |
| Partner | Purchasing Manager |

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such arbitration, action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall

be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 18-10701 on the day and year last shown below.

| [VENDOR NAME] Edelstein Gilbert Robson-Smith, LLC | CalOptima |
|---|---|
| By: [signature] | By: [signature] |
| Print Name: Trent E. Smith | Print Name: Greg Hamblin |
| Title: Manager | Title: CFO & Treasurer |
| Date: August 16, 2018 | Date: 9-4-18 |

| | |
|---|---|
| By: | [signature] |
| Print Name: | Donald B. Gilbert |
| Title: | Manager |
| Date: | August 16, 2018 |

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

**Exhibit A**

A. SCOPE OF WORK

CONSULTANT shall represent CalOptima's day-to-day interests in Sacramento with the California State Legislature, the Administration, and other relevant departments and agencies, offering legislative monitoring and other necessary advocacy services to CalOptima.

B. REPORTING RELATIONSHIP

The Chief Executive Officer; Executive Director, Public Policy and Public Affairs; and Director, Government Affairs (Business Owners) and/or their designee(s) will be the primary contacts and will direct the work of the CONSULTANT. All work in excess of that expressed in this Scope of Work shall be approved by the Business Owners in conjunction with the Purchasing department. This additional work will be evidenced in an amendment to this Contract prior to the work commencing.

C. OBJECTIVES/DELIVERABLES

CONSULTANT shall:

1. Maintain regular contact with members of the California Legislature, committee staff, and other state departments, agencies, boards and commissions, to identify impending changes in laws, regulations and funding priorities that relate to CalOptima.

2. Provide a written monthly report that shall accompany the invoice to describe the nature and extent of the services or actions taken on behalf of CalOptima as well as report on issues in Sacramento that may impact CalOptima's programs and funding. Written reports should also include general information regarding the health care industry in California that may have a direct or indirect impact on CalOptima.

3. Notify CalOptima of anticipated, introduced or amended state legislation, and regulations that could impact CalOptima. These activities include but are not limited to:

   Providing bill numbers and a brief summary of introduced or amended state legislation;

   Providing copies of legislation and committee analysis; and

   Providing information related to legislative hearings.

4. Advocate for CalOptima's programs and positions on proposed legislation, proposed regulations, and funding priorities as directed. These activities shall include by are not limited to:

Informing CalOptima of upcoming legislative proposals, budget forecasts and relevant policy issues;

Assisting in securing authors and drafting language for sponsored bills;

Assisting in drafting amendments to legislation;

Testifying on behalf of CalOptima at legislative hearings; and

Monitoring, reviewing and providing ongoing advice regarding the impact of the State budget on CalOptima's programs
Drafting letters of support/opposition

5. Provide copies of all written correspondence, testimony and position papers given on behalf of CalOptima, as well as provide copies of the State Budget and any related documents to the Business Owners.

**Exhibit B**

## PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a monthly basis. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 18-10701 provide a description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed One Hundred Thousand Dollars ($100,000), for the initial contract term including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

E. CONTRACTOR's billable rate shall be Eight Thousand Three Hundred Thirty-Three Dollars and Thirty-Three Cents $8,333.33 per month. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on aa as-needed basis for travel-related expenses to CalOptima. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client.

Exhibit C

CalOptima Travel Policy

Policy #: GA.5004
Title: **Travel Policy**
Department: Finance
Section: Purchasing
CEO Approval: Michael Schrader *MS*
Effective Date: 8/1/12 Revised: 9/6/12, 3/1/13
Board Approval: 9/6/12

## I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

## II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

b. Lodging;

c. Meals;

d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

e. Insurance for rental vehicles;

f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

   i. Authorized local and long-distance telephone calls;

   ii. Baggage fees;

   iii. Internet or Wi-Fi charges;

   iv. Facsimiles;

   v. Expenses in connection with the preparation of authorized company reports or correspondence;

   vi. Taxi or public transit fares, required to conduct business; and

   vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

   a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

   b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

      i. CalOptima business-related activities;

      ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

      iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

| Individual | Approver |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee |
| CEO | Board Chairperson or designee |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee |

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

    a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

    b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

    c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

    d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

    e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

    f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

    g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

    a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

## III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

| Individual | Approver |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee |
| CEO | Board Chairperson or designee |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee |

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

| Individual | Approver |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee* |
| CEO | Board Chairperson or designee* |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee* |

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

## IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

## V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

## VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

## VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

## VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

## Exhibit D

## MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Edelstein, Gilbert, Robson & Smith, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: [signature] Date: August 16, 2018

Print Name: Trent E. Smith

Title: Manager

**Exhibit E**
**Part 1**

**STATE OF CALIFORNIA**
**DEPARTMENT OF HEALTH CARE SERVICES**
**CERTIFICATION REGARDING LOBBYING**

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

| | |
|---|---|
| Edelstein Gilbert Robson + Smith, LLC<br>Name of Contractor | Trent E. Smith<br>Printed Name of Person Signing for Contractor |
| Contract No. 18-10701<br>Contract/Grant Number | [signature]<br>Signature of Person Signing for Contractor |
| August 16, 2018<br>Date | Manager<br>Title |

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

**Exhibit I**

**Officer, Owner, Shareholder, and Creditor Information**

Contractor's Business Name: Edelstein Gilbert Robson & Smith, LLC

Business Entity Type: Limited Liability Corporation
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 1127 11th St, Ste. 1030

City: Sacramento State: CA Zip: 95814

Business Phone: 916-443-6400 Email: : trent@egrslobby.com

President: ______ Contact Person: Trent E. Smith

Person(s) Signing Contract & Title: : Trent E Smith, Manager

*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 % |
|---|---|
| Donald B. Gilbert | Manager 40.5 % |
| Michael R. Robson | Manager 31 % |
| Trent E. Smith | Manager 28.5 % |
| | |

**BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.**

[signature]
Authorized Signature

August 16, 2018
Date

Trent E. Smith, Manager
Name and Title

**Exhibit J**

Not applicable for this Contract

## Exhibit K

Not applicable for this Contract

**Exhibit L**

Not applicable for this Contract

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken June 6, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

34. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

**Contact**

Silver Ho, Executive Director, Compliance, (714) 246-8400

**Recommended Action**

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise an option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2019.

**Background**

CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized a contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year extension options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2019.

**Discussion**

Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, budget legislation impacting the transition of the California Children's Services program, Proposition 56 implementation, the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), the Denti-Cal program, and Medi-Cal funding and rate issues.

As proposed, the recommended action is to extend Edelstein Gilbert Robson & Smith's contract for an additional one-year term, by exercising the first of the four one-year extension options under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will continue to monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**

Funding for the recommended action to extend the contract from July 1, 2019, through June 30, 2020, with Edelstein Gilbert Robson & Smith for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2019–20 Operating Budget pending Board approval.

**Rationale for Recommendation**

State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

*/s/ Michael Schrader* *5/29/2019*
**Authorized Signature** **Date**

# CalOptima Board Action Agenda Referral

**Action To Be Taken June 7, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

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

**Recommended Actions**
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

**Discussion**
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

**Rationale for Recommendation**
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

*/s/ Michael Schrader* | *5/30/2018*
**Authorized Signature** | **Date**

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AMENDMENT NO. 1 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of July 1, 2019, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. The Parties desire to amend the Contract to take advantage of the first (1st) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2020.

2. All other terms and conditions of the Contract remain unchanged.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year last shown below.

| EDELSTEIN, GILBERT, ROBSON & SMITH | CALOPTIMA |
|---|---|
| By: [signature] | By: [signature] |
| Print Name: Trent Smith | Print Name: Michael Schrader |
| Its: Partner | Its: Chief Executive Officer |
| Date: 8/1/2019 | Date: 8-2-19 |

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# CalOptima Board Action Agenda Referral

**Action To Be Taken June 4, 2020**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
21. Consider Authorizing Extension of State Legislative Advocacy Services Contract

**Contact**
Silver Ho, Executive Director, Compliance, (714) 246-8400

**Recommended Action**
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise the option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2020.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized the Chief Executive Officer to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. On June 6, 2019, the Board exercised the first one-year option. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2020.

**Discussion**
Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, Proposition 56 implementation, the CalOptima Program of All-Inclusive Care for the Elderly (PACE), the Denti-Cal program, and COVID-19 legislation and State response.

As proposed, the recommended action is to extend Edelstein Gilbert Robson & Smith's contract for an additional one-year term, per the option exercisable at CalOptima's discretion under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions

with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**
Funding for the recommended action to extend the contract from July 1, 2020, through June 30, 2021, with Edelstein Gilbert Robson & Smith for state legislative advocacy services is included in the proposed CalOptima Fiscal Year 2020–21 Operating Budget pending Board approval.

**Rationale for Recommendation**
State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services
2. Board Action dated June 6, 2019, Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

*/s/ Richard Sanchez* *05/27/2020*
**Authorized Signature** **Date**

# CalOptima Board Action Agenda Referral

**Action To Be Taken June 7, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

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

**Recommended Actions**
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

**Discussion**
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.


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Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

**Rationale for Recommendation**
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

*/s/ Michael Schrader* *5/30/2018*
**Authorized Signature** **Date**


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**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken June 6, 2019**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
34. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

**Contact**
Silver Ho, Executive Director, Compliance, (714) 246-8400

**Recommended Action**
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise an option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2019.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Edelstein Gilbert Robson & Smith. On June 7, 2018, the Board authorized a contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year extension options, each exercisable at CalOptima's sole discretion and commencing on July 1, 2018. Edelstein Gilbert Robson & Smith's current contract term ends on June 30, 2019.

**Discussion**
Edelstein Gilbert Robson & Smith has substantial knowledge and experience in health care issues important to CalOptima. In the past year, they have engaged with issues including, but not limited to, budget legislation impacting the transition of the California Children's Services program, Proposition 56 implementation, the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), the Denti-Cal program, and Medi-Cal funding and rate issues.

As proposed, the recommended action is to extend Edelstein Gilbert Robson & Smith's contract for an additional one-year term, by exercising the first of the four one-year extension options under the current contract. Edelstein Gilbert Robson & Smith's contract fee is $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.


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Consistent with CalOptima's practice, staff will continue to monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**

Funding for the recommended action to extend the contract from July 1, 2019, through June 30, 2020, with Edelstein Gilbert Robson & Smith for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2019–20 Operating Budget pending Board approval.

**Rationale for Recommendation**

State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Board Action dated June 7, 2018, Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

*/s/ Michael Schrader* *5/29/2019*
**Authorized Signature** **Date**


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# CalOptima Board Action Agenda Referral

**Action To Be Taken June 7, 2018**
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

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

**Recommended Actions**
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

**Background**
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

**Discussion**
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.


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Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

**Fiscal Impact**
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

**Rationale for Recommendation**
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

**Concurrence**
Gary Crockett, Chief Counsel

**Attachments**
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

*/s/ Michael Schrader* *5/30/2018*
**Authorized Signature** **Date**


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AMENDMENT NO. 2 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of July 1, 2020, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services. Amendment No. 1 was entered into as of July 1, 2019.

B. The Parties desire to amend the Contract to take advantage of the second (2nd) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2021.
2. All other terms and conditions of the Contract remain unchanged.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year last shown below.

| EDELSTEIN, GILBERT, ROBSON & SMITH | CALOPTIMA |
|---|---|
| By: [signature] | DocuSigned by: By: Richard Sanchez 234AD421BDEC4D9... |
| Print Name: Trent Smith | Print Name: Richard Sanchez |
| Its: Partner, EGRS | Its: Interim Chief Executive Officer |
| Date: 8/10/2020 | Date: 08/24/2020 |

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AMENDMENT NO. 3 TO CONTRACT NO. 18-10701
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA
CALOPTIMA
(CalOptima)
AND
EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 3 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. Amendment No. 1 was entered into as of July 1, 2019, and Amendment No. 2 was entered into as of July 1, 2020.

C. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

D. The Parties now desire to extend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Pursuant to Section 15 of the Contract, the third of four Extended Terms is hereby executed to extend the Contract Term to June 30, 2022.

2. **No Other Changes**. This Amendment No. 3 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 3 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

**[Signature to follow on next page]**

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 to Contract 18-10701 on the day and year last shown below.

| EDELSTEIN, GILBERT, ROBSON & SMITH | CALOPTIMA |
|---|---|
| Signature: [signature] | Signature: |
| Print Name: Trent Smith | Print Name : |
| Title: Partner/Manager | Title: |
| Date: 4/8/2021 | Date: |
| | |
| Signature: | Signature: |
| Print Name: | Print Name : |
| Title: | Title: |
| Date: | Date: |

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 6, 2021
Regular Meeting of the CalOptima Board of Directors

**Report Item**
17. Consider Selecting and Contracting with a Vendor for Federal Advocacy Services

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

**Recommended Actions**
1. Approve recommended federal advocacy firm Potomac Partners DC to represent CalOptima for federal regulatory and legislative advocacy services;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended vendor for federal advocacy services at a monthly rate not to exceed $12,500 per month plus approved expenses for the period of May 21, 2021 through June 30, 2024, plus two one-year extension options, each exercisable at CalOptima's sole discretion; and
3. Authorize expenditures per the terms of the proposed contract.

**Background**
As part of its Government Affairs program, and in addition to work with various trade associations, CalOptima retains representation in Washington, D.C., to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

The CalOptima Board of Directors authorized a contract with Akin Gump Strauss Hauer & Feld LLP (Akin Gump) to provide federal advocacy services commencing on February 21, 2017. The contract was for an initial three-year term, and included two one-year extension options, each exercisable at CalOptima sole discretion. At the Board's February 6, 2020 meeting, it authorized exercise of the first of these one-year options, extending the Akin Gump contract through February 20, 2021. On February 4, 2021, the Board authorized a three-month extension of the Akin Gump contract to allow time for staff and a Board ad hoc committee to complete a Request for Proposal (RFP) process and recommend a federal advocacy firm going forward to the full Board. As such, CalOptima's current contract with Akin Gump expires on May 20, 2021.

Consistent with CalOptima's procurement processes, an RFP for federal advocacy services was issued on December 8, 2020, and a total of four proposals were received: Akin Gump, McDermottPlus, Potomac Partners DC, and Townsend Public Affairs. An evaluation committee comprised of staff and two external stakeholder representatives reviewed the submitted proposals. Three of the firms were recommended for interviews (Akin Gump, McDermottPlus and Potomac Partners) before a Board Ad Hoc committee, which included Chair Andrew Do, Vice Chair Isabel Becerra, and Director J. Scott Schoeffel. After evaluating the proposals and conducting in-person interviews, the Board Ad Hoc committee recommends Potomac Partners DC to provide federal advocacy services for CalOptima.

**Discussion**

Due to the substantial knowledge in health care issues important to CalOptima, including Medicaid, Medicare, and the Affordable Care Act (ACA) brought by their firm and subcontractors, the Board Ad Hoc committee recommends Potomac Partners DC for Federal Advocacy Services. The proposed team has broad healthcare experience, a depth of resources, and strong connections with key influencers within the healthcare field, Congressional leadership, and the current administration. Staff and the Board Ad Hoc committee believe Potomac Partners DC will provide added value to CalOptima's advocacy efforts.

Consistent with CalOptima's practice, staff will monitor the performance of Potomac Partners DC to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates, and discussions with staff. When appropriate, occasional verbal updates will be provided at Board of Directors meetings.

Staff recommends Board authorization of the proposed contract with Potomac Partners DC for the period of May 21, 2021, through June 30, 2024, in order to align the end of the contract period with the end of CalOptima's Fiscal Year (FY) 2023-24 budget cycle. The proposed contract also includes two one-year extension options, each exercisable at CalOptima's sole discretion with the approval of the Board of Directors.

Based on the current federal lobbyist contract, the CalOptima FY 2020-21 Operating Budget included $10,000 per month for federal advocacy services, as well as $10,000 for any CalOptima-approved travel reimbursements. Pursuant to the submitted proposal, Potomac Partners DC's proposed contract is priced at $12,500 per month for the period of May 21, 2021, to June 30, 2024. Consistent with its increased pricing above the current levels, Potomac Partners DC will commit additional staff and labor hours in comparison to CalOptima's current contract for federal advocacy services. As a result of the COVID-19 pandemic, there are available travel reimbursement funds in the FY 2020-21 budget to fund the increased cost. The proposed contract price includes direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, and materials. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima, and in an amount not to exceed $5,000 per year.

**Fiscal Impact**

Budgeted funds for federal legislative advocacy services under the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020, are sufficient to cover projected expenses associated with the contract with Potomac Partners DC for the period of May 21, 2021, through June 30, 2021. Management plans to include updated expenses for federal advocacy services for the period of July 1, 2021, through June 30, 2024, in future operating budgets.

**Rationale for Recommendation**

Federal advocacy efforts continue to be a priority for CalOptima given the stated health care-related priorities of the new presidential administration and Congressional majorities. CalOptima staff anticipates that several important health care issues will require focus, attention, involvement, and advocacy at the federal level in the coming years.

**Concurrence**

Gary Crockett, Chief Counsel

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**Attachments**

1. Entities Covered by this Recommended Action
2. Proposed CalOptima Contract with Potomac Partners DC

*/s/ Richard Sanchez* *04/29/2021*
**Authorized Signature** **Date**

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**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Akin Gump Strauss Hauer & Feld LLP | 2001 K Street NW | Washington | DC | 20006 |
| McDermott+Consulting LLC (McDermottPlus) | 500 N Capitol St NW | Washington | DC | 20001 |
| Potomac Partners DC | 700 Pennsylvania Ave SE, Suite 320 | Washington | DC | 20003 |
| Townsend Public Affairs, Inc. | 600 Pennsylvania Ave SE, Suite 207 | Washington | DC | 20003 |

CONTRACT NO. 21-10013
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
POTOMAC PARTNERS DC, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of May 21, 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Potomac Partners DC, a LLC, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide National Legislative Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 21-018, inclusive of any revisions, amendments and addenda thereto; and (iii) CONTRACTOR's proposal dated January 6, 2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated January 6, 2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

| Name | Function/Title |
| --- | --- |
| Rick Alcalde | Founder & President, Project Manager |
| Dan Felix | Managing Partner |
| Adam Cross | Legislative Specialist |
| Paul Lee | Sr. Partner and Founder of Strategic Health Care, (Subcontractor) |
| David Introcaso, Ph.D. | VP, Regulatory Policy for Strategic Health Care, (Subcontractor) |

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%)

of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "Consultant" pursuant to CalOptima's Conflict of Interest Code, and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually.

10.5 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.6 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. <u>Equal Opportunity</u>.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's

inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed

and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence May 21, 2021 and shall continue in full force and effect through 6/30/2024, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information,

materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights.

CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

| To CONTRACTOR: | To CalOptima: |
|---|---|
| Potomac Partners DC, LLC | CalOptima |
| 700 Pennsylvania Ave SE, Suite 320 | 505 City Parkway West |
| Washington, DC 20003 | Orange, CA 92868 |
| Attention: Rick Alcalde | Attention: Ryan Prest, MBA, CPSM, CPPB |

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5)

working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that

potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 21-10013 on the day and year last shown below which shall commence as of the date in Section 15.

| Potomac Partners DC, LLC | CalOptima |
|---|---|
| By: Rick Alcalde | By: |
| Print Name: Rick Alcalde | Print Name: |
| Title: President, Potomac Partners DC<br>Date: 04/09/2021 | Title:<br>Date: |

| By: Dan Feliz | By: |
|---|---|
| Print Name: Dan Feliz | Print Name: |
| Title: Managing Partner, Potomac Partners DC<br>Date: 04/09/2021 | Title:<br>Date: |

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

**Exhibit A**

**SCOPE OF WORK**

A. Purpose:
CONTRACTOR shall represent CalOptima's interests in Washington D.C. and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships, and providing CalOptima with necessary advocacy services.

B. Reporting Relationship:
CalOptima's Government/Legislative Affairs Department staff will be the primary CalOptima contacts and will direct the work of the CONTRACTOR. Any work determined to be beyond the scope of this Contract will be approved by the Government/Legislative Affairs Department in conjunction with the CalOptima Vendor Management Department. This additional work will not be provided or have fees incurred until an Amendment has signed by both CalOptima and CONTRACTOR.

C. Objective/Deliverables:
CONTRACTOR shall:

1. Maintain regular contact with the Administration, members of Congress, specifically the Orange County congressional delegation, legislative staff, and committee staff to identify impending changes in laws, new program opportunities, and funding priorities that relate to CalOptima. When directed by CalOptima, CONTRACTOR shall also communicate with federal departments, agencies, boards, committees, committees and staff regarding identified issues.

2. As directed by CalOptima, brief Orange County congressional delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

3. Arrange meetings and briefings for CalOptima Board and staff with elected officials and legislative staff. CONTRACTOR shall be proactive in scheduling strategic, targeted meetings and briefings especially, but not limited to, times when CalOptima Board and staff are scheduled to be in Washington, D.C. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

4. Provide monthly, written reports which shall include a federal budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the meetings CONTRACTOR had along with the issues discussed with members of Congress, specifically the Orange County congressional delegation, legislative staff, relevant committee staff as well as appropriate departments, agencies, boards, and commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff, and may be included in the CalOptima board book and/or provided to board members. The frequency of written reports may be modified at any time.

5. Provide in-person or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima board and executive staff.

6. Notify CalOptima of anticipated, introduced or amended federal legislation, and proposed regulations which could impact CalOptima. These activities include, but are not limited to:
   - Providing the bill number and brief summary of introduced or amended federal legislation;
   - Providing copies of legislation and committee analysis;
   - Providing information relative to legislative hearings; and

- Providing a brief summary of proposed or final federal regulations.

Additionally, CONTRACTOR shall advocate for CalOptima's programs and positions regarding proposed legislation, proposed regulations, and funding priorities as directed.

Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the federal budget and any related documents (Congressional Budget Office analysis, etc.) as they become available.

CalOptima staff may prepare a formal annual review of CONTRACTORs work product at the end of each calendar/fiscal year.

**Exhibit B**

**PAYMENT**

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a fixed monthly retainer basis. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a detailed monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 21-10013; detailed description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that for the period of July 1 through June 30 annually, CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Twelve Thousand Five Hundred Dollars ($12,500.00) per month equaling One Hundred Fifty Thousand Dollars ($150,000.00) annually, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. Additionally, to clarify for the period of May 21, 2021 through May 31, 2021, the fee’s will be prorated at 11 out of 31 days, equaling Four Thousand Four Hundred Thirty-Five Dollars ($4,435.00), and June 1, 2021 through June 30, 2021 will be at the full monthly rate of Twelve Thousand Five Hundred Dollars ($12,500.00). Beginning July 1,2021, the payments outlined in Section D above will begin.

F. Not included in the maximum cumulative payment obligation above in Section D, CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima’s Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed Five Thousand Dollars ($5,000.00) in the aggregate. CalOptima shall not pay CONTRACTOR for time spent traveling.

**Exhibit B-1**

Not applicable for this Contract

**Exhibit C**

**CalOptima Travel Policy**

Policy #: GA.5004
Title: **Travel Policy**
Department: Finance
Section: Purchasing
CEO Approval: Michael Schrader MS
Effective Date: 8/1/12 Revised: 9/6/12, 3/1/13
Board Approval: 9/6/12

## I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

## II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

   i. Authorized local and long-distance telephone calls;

   ii. Baggage fees;

   iii. Internet or Wi-Fi charges;

   iv. Facsimiles;

   v. Expenses in connection with the preparation of authorized company reports or correspondence;

   vi. Taxi or public transit fares, required to conduct business; and

   vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

   a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

   b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

      i. CalOptima business-related activities;

      ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

      iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

| Individual | Approver |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee |
| CEO | Board Chairperson or designee |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee |

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

   a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

   b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

   c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

   d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

   e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

   f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

   g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

   a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

## III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

| Individual | Approver |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee |
| CEO | Board Chairperson or designee |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee |

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

| **Individual** | **Approver** |
|---|---|
| Employee through Department Manager | Department Director |
| Department Director | Executive Management |
| Executive Officer | CEO or designee* |
| CEO | Board Chairperson or designee* |
| Board Member/Standing Committee Member | Board Chairperson, CEO or designee* |

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

   1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

## IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

## V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

## VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

## VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

## VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

**Exhibit D**

**MEDI-CAL DATA ACCESS AGREEMENT**

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Potomac Partners DC, LLC, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: Rick Alcalde Date: 04/09/2021

Print Name: Rick Alcalde

Title: President, Potomac Partners DC

**Exhibit E**
**Part 1**

**STATE OF CALIFORNIA**
**DEPARTMENT OF HEALTH CARE SERVICES**
**CERTIFICATION REGARDING LOBBYING**

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

| | |
|---|---|
| Potomac Partners DC | Rick Alcalde |
| Name of Contractor | Printed Name of Person Signing for Contractor |
| 21-10013 | Rick Alcalde |
| Contract/Grant Number | Signature of Person Signing for Contractor |
| 04/09/2021 | President, Potomac Partners DC |
| 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



Back to Item

Back to Agenda

**Exhibit E**

**Part 2**

## CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

(See reverse for public burden disclosure)

| 1. Type of Federal Action: | 2. Status of Federal Action: | 3. Report Type: |
|---|---|---|
| ☐a. contract ☐b. grant<br>☐c. cooperative agreement<br>☐d. loan<br>☐e. loan guarantee<br>☐f. loan insurance | ☐a. bid/offer/application<br>☐b. initial award<br>☐c. post-award | ☐a. initial filing<br>☐b. material change<br>**For Material Change Only:**<br>Year ______ quarter________<br>date of last report ______________ |

| | |
|---|---|
| 4. Name and Address of Reporting Entity:<br>☐ Prime ☐ Subawardee<br>Tier ____, *if known*:<br>Congressional District, *if known*: | 5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:<br>Congressional District, *if known*: |
| 6. Federal Department/Agency: | 7. Federal Program Name/Description:<br>CDFA Number, *if applicable*: |
| 8. Federal Action Number, *if known*: | 9. Award Amount, *if known*:<br>$_________________ |
| 10. a. Name and Address of Lobbying Entity<br>(*If individual, last name, first name, MI*): | b. Name and Address of Lobbying Entity<br>(If individual, last name, first name, MI): |

(*attach Continuation Sheet(s) SF-LLLA, if necessary*)

| | |
|---|---|
| 11. Amount of Payment (check all that apply):<br>$________________ ☐actual ☐planned<br><br>12. Form of Payment (check all that apply):<br>☐ a. cash<br>☐ b. in-kind, specify: Nature ______________<br>Value______________ | 13. Type of Payment<br>☐ a. retainer<br>☐ b. one-time fee<br>☐ c. commission<br>☐ d. contingent fee<br>☐ e. deferred<br>☐ 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:<br>Print Name:<br>Title:<br>Telephone No.: Date: |
| **Federal Use Only** | Authorized for Local Reproduction<br>Standard Form-LLL |

# Exhibit E

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

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 for this Contract

**Exhibit G**

**ADDENDUM 1**
**MEDICARE ADVANTAGE PROGRAM**

The following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

B. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

   1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purpose or purposes the information will be used within CONTRACTOR's organization; and (b) to whom and for what purpose CONTRACTOR will disclose the information.

   2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

   3. Maintain the records and information in an accurate and timely manner.

   4. Ensure timely access by enrollees to the records and information that pertain to them.

C. CONTRACTOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR Section 422.257.

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

   1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-300.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED PROTECTED VETERANS, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED PROTECTED VETERANS.** (41 CFR 60-300.5(d).)

   2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-741.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS ON THE BASIS OF DISABILITY, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED INDIVIDUALS WITH DISABILITIES.** (41 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 16 of this Contract, CONTRACTOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that

CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

F. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, CONTRACTOR shall comply with all such requirements at the direction of CalOptima.

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

H. Notwithstanding the delegation by CalOptima to CONTRACTOR for the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

I. Notwithstanding the written delegation by CalOptima to CONTRACTOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with CONTRACTOR. With all such delegated activities, CalOptima shall monitor CONTRACTOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

**Exhibit H**

Not applicable for this Contract

**Exhibit I**

## Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Potomac Partners DC

Business Entity Type: LLC
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 700 Pennsylvania Ave SE, Suite 320

City: Washington State: DC Zip: 20003

Business Phone: 202-544-4848 Email: : RICK@PPDC.PRO

President: Rick Alcalde Contact Person: Rick Alcalde

Person(s) Signing Contract & Title: : Rick Alcalde, President

*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 % |
|---|---|
| Rick Alcalde | President, 100% Ownership |
| | |
| | |
| | |

**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.**

Rick Alcalde
Authorized Signature

04/09/2021
Date

Rick Alcalde, President
Name and Title

**Exhibit J**

Not applicable for this Contract

**Exhibit K**

Not applicable for this Contract

**Exhibit L**

Not applicable for this Contract

# Member Advisory Committee Update
# Board of Directors Meeting
# May 6, 2021

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On April 8, 2021, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Ladan Khamseh, Chief Operating Officer, updated the MAC members on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. She noted that the policy includes draft language that is intended to define the criteria and provided the process for health networks to submit requests for contract model changes. She also noted that staff plans to submit this policy for board consideration at its May 2021 meeting.

Emily Fonda, Chief Medical Officer, provided a comprehensive COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress and noted that over 9,350 gift cards had been sent to CalOptima members as an incentive for getting their vaccine. Dr. Fonda also discussed the vaccine initiatives for those members who are homeless and addressed the myths that were circulating about the vaccines.

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback on the topic of the FY 2020-2022 Strategic Plan update received from the March 11, 2021 joint meeting of the advisory committees and the direction to solicit additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories _from the MAC prior to finalizing their report. Ms. Selleck also provided the MAC with a Federal and State Legislative update.

MAC members also received a presentation from MAC member Maura Byron on the Family Support Network and how the organization assists families in need.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

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## Provider Advisory Committee (PAC) Update
## Board of Directors Meeting
## May 6, 2021

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On April 8, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Chief Executive Officer, provided an update and announced that Emily Fonda, M.D. has been named CalOptima's Chief Medical Officer. Mr. Sanchez also provided an update on COVID vaccines and noted that Blue Shield was now acting as the state's third party administrator for vaccine distribution. He also shared that CalOptima was continuing to work closely with the County on local vaccine distribution.

Ladan Khamseh, Chief Operating Officer, updated the PAC members on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. She noted that the policy includes draft language that is intended to define the criteria and provides the process for health networks to submit requests for contract model changes. She noted that staff plans to submit this policy for board consideration at its May 2021 meeting.

Nancy Huang, Chief Financial Officer, provided an update on CalOptima's financials and provided an overview of items such as enrollment projections for all lines of business. She also discussed the FY 2021-22 anticipated Medi-Cal revenue impact and the pre-and post-pandemic effects on all aspects of CalOptima's budget.

Emily Fonda, Chief Medical Officer, provided a comprehensive COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress and noted the 9,350 gift cards have been sent to members as a incentive for getting vaccinated. She also discussed the vaccine initiatives for members experiencing homelessness and referenced a number of myths circulating about the vaccines.

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback received from the advisory committee's joint meeting on March 11, 2021 on Health Equity, Social Determinants of Health, Service Delivery Model, Behavioral Health and other categories and to solicit further feedback from the PAC on the FY 2020-2022 Strategic Plan update prior to finalizing their report. Ms. Selleck also provided the PAC with a Federal and State Legislative update.

PAC member, Christy Ward, Chief Executive Officer of Share Our Selves (SOS), presented on how SOS is helping the Orange County community during COVID-19.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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